California Department of Veterans Affairs:

The Veterans Home at Yountville Could Decrease Costs, Increase Revenues, and Improve the Quality of Care Provided to its Residents by Utilizing Accepted Industry and Managed Care Techniques

January 1997
96035

The first copy of each California State Auditor report is free.
Additional copies are $3 each. You can obtain reports by contacting
the Bureau of State Audits at the following address:

California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814
(916) 445-0255 or TDD (916) 445-0255 x 248

OR

This report may also be available
on the worldwide web
http://www.bsa.ca.gov/bsa/

January 29, 1997 96035

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As required by the Budget Act of 1996, the Bureau of State Audits presents its audit report concerning the medical operations of the California Veterans Home at Yountville (Yountville). This report was prepared under contract by Ernst & Young LLP.

This report concludes that Yountville has many opportunities to decrease costs, increase efficiencies, generate additional revenues, and improve the quality of care of its residents. Specifically, our consultants concluded that Yountville could allow veterans to remain in their veteran's home residential setting while providing nursing care through a home health care function. They also noted that Yountville incurs more than $1.8 million annually in unreimbursed physician costs because of either excess physicians, low productivity, inadequate billing, or a combination of all three. Among their other issues, our consultants expressed concerns about the cost-effectiveness of Yountville's 26-bed hospital and higher-than-industry average nursing staff ratios. Finally, our consultants concluded that Yountville could reduce its dietary and laundry costs by approximately $2.3 million annually by contracting with outside services.

Respectfully submitted,

Kurt Sjoberg

KURT R. SJOBERG
State Auditor

ERNST & YOUNG LLP

■ **Certified Public Accountants**
Suite 2200
100 North Tampa Street
P.O. Box 740
Tampa, Florida 33601

■ Phone: 813 225 4800

January 24, 1997

Mr. Kurt R. Sjoberg
California State Auditor
Bureau of State Audits
660 J. Street, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

We are pleased to submit our report on the Veterans Home of Yountville (Home). The primary purpose of the report was to identify meaningful opportunities to improve the financial results of the Home, while maintaining the overall quality of resident and patient care.

We appreciate the substantial assistance the Bureau of State Audits provided, particularly the assistance of Mr. Fred Forrer. Please contact Mr. J. Talbot Land or Mr. Kevin Cornish at 813/225-4800 should you need any additional information.

Very truly yours,

Ernst & Young LLP

California Department of Veterans Affairs:

The Veterans Home at Yountville Could Decrease Costs, Increase Revenues, and Improve the Quality of Care Provided to its Residents by Utilizing Accepted Industry and Managed Care Techniques

Table of Contents

Summary

Results in Brief

Audit Highlights . . .

The Veterans Home at Yountville (Yountville) has many opportunities to decrease costs, increase efficiencies, generate additional revenues, and improve the quality of care to its residents. Specifically, we found:

- ☑ ***Yountville could allow veterans to remain in their veteran's home residences longer by providing nursing care through a home health care function.***
- ☑ ***Yountville incurs more than $1.8 million annually in unreimbursed physician costs because of either excess physicians, low productivity, inadequate billing, or all three.***
- ☑ ***Its 26-bed hospital has low utilization and is not cost-effective.***
- ☑ ***Nursing staff ratios are higher than industry standards and are significantly above state averages.***
- ☑ ***Yountville could significantly reduce dietary and laundry costs by contracting with outside services.***

The Veterans Home at Yountville (Yountville) is a state-owned and operated health care provider in northern California. Yountville's mission is to serve California veterans with an environment that improves the overall health of veterans residing at Yountville by reducing the incidence and severity of disabilities, maintaining and improving functions, increasing social interaction, and promoting self-reliance and self-worth.

Yountville provides health-related services based on the health care needs of veterans. Care decisions are not based on the veterans' ability to fully pay for the services they require. The costs of care that either the veterans' or applicable state or federal health programs are unable to pay are covered by the State's General Fund.

During fiscal year 1995-96, the General Fund subsidized Yountville's operations with $25 million, or approximately 50 percent of Yountville's operating budget. Because of the availability of General Fund subsidies, Yountville has historically not placed emphasis on productivity and performance measurements. This is evident when certain Yountville operating costs are compared to those of comparable health care providers in California. Because Yountville has not been held accountable to financial performance measures other than the annual budget, there is a lack of incentive and initiative to maximize reimbursement and reduce costs.

During our review, we noted the following conditions:

- Yountville is providing all of its intermediate and skilled nursing care in an institutional setting. However, we believe that Yountville can better serve its residents by providing nursing care in its residential areas. A home health agency is simply a licensed unit that would provide the same type of services that the veterans now receive in the intermediate or skilled nursing areas of Yountville, but in their own residences at Yountville.

- Yountville's physicians are on staff rather than the more common contracting on a fee-for-service basis. We also believe Yountville employs more staff physicians than

necessary. Because of either excess physicians on staff, low productivity among the physicians, or inadequate billing for physician visits, Yountville incurs more than $1.8 million in unreimbursed physician costs annually.

- Yountville operates a 26-bed acute care hospital. However, the small size of Yountville's hospital and its low utilization rates suggest that the hospital is not cost-effective. Yountville's own analysis indicates that the hospital's costs exceeded its reimbursements by $854,000 for fiscal year 1995-96. We also found that the hospital's radiology costs per procedure are 6 times greater than statewide averages, and pathology costs are 13 times greater than statewide averages. Finally, we question the quality of care provided at an unusually small hospital such as Yountville's versus the quality of care that can be obtained at nearby larger hospitals with more specialists and a greater pool of expertise.

- Yountville uses a higher-than-industry-average ratio of registered nurses (RNs) compared to the less costly licensed vocational nurses (LVNs), and nurses' aides (aides). We estimate that Yountville could save approximately $816,000 annually by shifting staffing ratios for RNs, LVNs, and aides to ranges consistent with statewide averages without decreasing the amount of direct nursing care received by the veterans. We also noted that the salaries for RNs and aides are significantly above state averages, while LVNs' salaries are lower.

- Yountville can maximize its Medicare reimbursement rates by creating a "certified distinct part" (CDP) within the institution. This allows the facility to isolate and report all of the costs associated with providing skilled nursing care to Medicare-eligible patients. We believe that Yountville's Medicare reimbursement rate is far lower than it would be if the rate were based upon costs captured in an appropriately sized and monitored CDP. We also found that some of the medical and administrative staff of Yountville lack the level of expertise in Medicare and Medi-Cal reimbursement techniques typically found in their counterparts in the industry.

- The proper utilization of nursing services is important to Yountville's financial viability as well as the veterans' quality of life. A number of issues that came to our attention during this review caused us to question whether Yountville is appropriately using skilled nursing care. We also noted that skilled nursing care was provided at two different locations at Yountville, which is inefficient.

- Throughout this audit, we noted numerous weaknesses resulting from Yountville's lack of an adequate management information system (MIS). Many of these same weaknesses were identified by the Bureau of State Audits in an audit of Yountville in 1994. The lack of an adequate MIS effectively precludes Yountville from utilizing many of the management techniques commonly used by the industry.

- We compared Yountville's costs of laundry and dietary services to those of the California Veterans Home at Barstow (Barstow), which are provided by outside contractors. Based upon those comparisons, we estimate Yountville could save approximately $2 million annually by contracting for dietary services and approximately $350,000 annually by contracting for laundry services.

Recommendations

Yountville should take the following actions to improve its medical operations:

- Renew its expired license for home health care and provide care to the veterans in their residences at Yountville whenever appropriate.

- If Yountville decides to retain its staff physicians, it should eliminate three inpatient staff physician positions, review outpatient physician staffing levels, and develop physician productivity standards. However, Yountville should consider the industry practice of using contracted physicians on a fee-for-service basis and eliminate staff physician positions.

- Either discontinue the operation of the hospital at Yountville and obtain hospital services through the local medical community or the Legislature should require a cost-benefit study of continuing the hospital and require the hospital's costs to be brought in line with statewide averages.

- Increase the utilization of LVNs and aides to be more consistent with industry average nursing ratios.

- Create a CDP within its skilled nursing facility commensurate with the size of its Medicare-eligible population.

- Require the appropriate medical and administrative staff to attend training on Medicare and Medi-Cal reimbursement regulations to improve their awareness of these issues.

- To ensure that veterans receive the appropriate level of nursing care in the most appropriate setting, the Legislature should require a study of veterans receiving skilled and intermediate care at Yountville to determine whether the veterans are placed in the appropriate level of care.

- Provide all skilled nursing services in one common area and separate skilled nursing veterans from intermediate care veterans.

- Make the development of an MIS a top priority and explore interim solutions for Yountville's MIS needs. In the absence of viable interim solutions, develop and utilize manual procedures to identify and record vital management information until automated solutions are developed.

- Outsource the laundry and dietary services using the same type of contractual arrangement as Barstow.

Agency Comments

The California Department of Veterans Affairs (DVA) generally concurs with most of our findings and recommendations. However, the DVA disagrees with our conclusion that Yountville has not been held accountable to financial performance measures other than the annual budget. The DVA agrees with the concept of home health care and plans to explore the licensing and staffing requirements. Also, the DVA would like to explore a number of alternatives for making the hospital more cost-effective and has agreed to reduce physician staffing and adjust the nursing staffing ratios. However, those staffing adjustments are more modest than the changes we suggest. The DVA raises some concerns about the CDP concept and questions the need for a review to determine whether veterans are being placed in the appropriate level of care. Finally, the DVA concurs with our observations and recommendations regarding its MIS and outsourcing laundry and dietary services.

Introduction

Background

The Veterans Home at Yountville (Yountville) is a long-term, residential care provider for elderly or disabled veterans and their spouses over age 62 and who are California residents. Yountville is administered by the California Department of Veterans Affairs (DVA). The DVA estimates that during the fiscal year ended June 30, 1996, Yountville cared for approximately 1,300 residents at a cost of $50 million. This equates to an annual cost per veteran of approximately $38,000. Yountville is one of the largest branches of the DVA, with approximately 953 full-time equivalent employees. Yountville is one of two homes the DVA oversees. The second home is located in Barstow. Also, two additional veterans homes are now planned.

Yountville was established in 1884 and has provided health care services to California veterans since its inception. Yountville's mission is to provide health care services promoting the health, welfare, and social interaction of veterans. To meet this objective, Yountville provides a wide array of health care services including the following:

- Residential living beds—116 beds
- Alcohol and drug treatment—29 beds
- Domiciliary services—767 beds
- Intermediate care facility (ICF)—177 beds
- Skilled nursing facility (SNF)—316 beds
- Hospital services—26 beds
- Surgical services
- Emergency services
- Outpatient clinics

Because of renovation of some buildings at Yountville, 79 skilled nursing beds and 497 intermediate care beds are currently licensed but are not in service or available for occupancy.

Residents in domiciliary and residential living areas are self-sufficient and are able to independently perform basic activities of daily living such as bathing, toileting, grooming, and mobility. They may also require assistance in other activities such as banking, medications, transportation, and housekeeping. Residents in the intermediate care areas require assistance with one to two activities of daily living and require

minimal nursing intervention. Residents in skilled areas require assistance in two or more activities of daily living and significant nursing and therapeutic intervention. Residents admitted to hospital beds require significant medical services and a high degree of physician and pharmacological services.

Health care services are available 24 hours a day, seven days a week. They include medical, nursing, dietary, and pharmaceutical services. Several of the health care services provided by Yountville are not typically provided by private nursing homes. The most significant departure is the provision of hospital, surgical, and emergency services. Managing hospital services requires significantly different managerial, clinical, and financial skills than are required to operate nursing homes or residential retirement facilities. In addition, the costs of providing acute (hospital) and surgical services requires a high number of patients to warrant required support services. Consequently, nursing homes typically contract for these services with local hospitals, instead of providing them directly.

Although Yountville directly provides hospital services, it is not required to do so. Section 1012 of the California Military Veterans Code states that the administration of Yountville must make available all services veterans may require. This means that the services can be provided directly by Yountville or contracted with community hospitals.

Historically, approximately 54 percent of funds to pay for services at Yountville have come from traditional health care sources such as Medicare, Medi-Cal, private pay, and members' fees. Tables 1 and 2 illustrate the reimbursement percentages received in fiscal year 1995-96.

Table 1

Percentage of Reimbursement by Payer Type

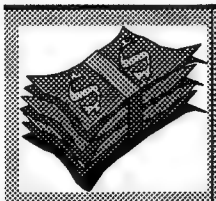
	*Medicare*	*Medi-Cal*	*Members' Fees*	*Federal Veterans Administration Aid and Attendance Allowance*	*Other*
1995-96	23%	9%	29%	3%	36%
Dollars	$7 million	$2 million	$8 million	$1 million	$10 million

Table 2

Percent and Dollars Contributed to Yountville by the State's General Fund

	1992-93	1993-94	1994-95	1995-96
Percent	53%	49%	49%	46%
Dollars	$20 million	$22 million	$24 million	$25 million

Source: The Veterans Home at Yountville, fiscal year expenditures and reimbursements report.

Expenses not covered by traditional reimbursement sources are paid by the State's General Fund. In fiscal year 1995-96, the General Fund contributed $25 million, or approximately 46 percent, to cover Yountville's expenses. Table 2 illustrates the trend in the amount of expenses paid by the General Fund.

To address Yountville's rising costs of care, members' fees were increased effective February 1, 1994. Members' fees are based on a veterans' required level of care. Veterans in residential levels of care are assessed 55 percent of their monthly income, or $1,200, whichever is less. Fees for intermediate care level services are assessed at 65 percent up to $2,300 per month, and skilled care and acute care services are assessed at 70 percent of income up to $2,500 per month. Documentation provided by Yountville management indicates that the average member fees are significantly below the maximums identified above. Average member fees collected for skilled care level veterans are approximately $822 per month. Average member fees collected for intermediate care level veterans are approximately $640 per month. It is not clear whether the low average collections are because of low monthly incomes of the veterans or Yountville not fully collecting members' fees.

Scope and Methodology

The Bureau of State Audits (bureau) completed a study of Yountville in April 1994. The report indicated that Yountville was not maximizing reimbursement and cost-reduction efforts. The Legislature raised further concerns regarding the medical and operational practices of Yountville and mandated a study in the 1996 Budget Act, Item Number 8960-011-0001, Provision Number 7.

The bureau hired consultants from Ernst & Young LLP, with expertise in the operations and reimbursement of hospital and nursing home health services to conduct an independent and objective performance assessment of the medical operations of the 26-bed hospital unit, the 316-bed skilled nursing areas, and the 177-bed intermediate care areas. This assessment resulted in recommendations for improving Yountville's medical and operational performance, reducing costs, and maximizing reimbursements.

In order to focus on areas with the most significant potential impact, we first identified Yountville's most significant cost areas. Because of Yountville's unique nature, it was important that we gained a detailed understanding of the operational and regulatory factors that influence how care is delivered and reimbursed. This knowledge was gained through reviewing a comprehensive list of requested materials and interviews with executive and departmental level personnel at Yountville.

We assessed what services Yountville was required to provide through state or federal laws, regulations, or agreements. A preliminary assessment was then made as to which services could be potentially outsourced if more cost-effective alternatives were available without compromising Yountville's mission.

To determine whether Yountville effectively managed the hospital's skilled care and intermediate care areas, we identified applicable industry benchmarks for comparison. We requested data for nursing home and hospital facilities through the Office of Statewide Health Planning and Development (OSHPD) for fiscal year 1994-95. Nursing home data was segregated by profit, not-for-profit, and government-owned facilities. Hospital data was limited to 25 facilities in northern California as defined by the OSHPD, ranging in size from 16 to 80 beds, with an average of 57 beds.

Key benchmarks determined through these sources were then compared to Yountville's cost data for the same time period—fiscal year 1994-95. Specifically, we looked at the use of medical personnel, the salary ranges for specific employee categories, and cost-effectiveness of specific patient care services.

The consultants' scope of our review also included:

- Assessed use of managed care techniques to monitor utilization of medical services;

- review of Yountville's admissions criteria and state regulatory requirements for three distinct patient care areas—hospital, skilled care, and intermediate care;

- review of case management techniques to identify whether Yountville was caring for veterans in the most appropriate and least-costly environment; and

- review of the level of physician interaction in the case management process and how physician interaction benefited or detracted from the case management process.

Chapter 1

The Veterans Home at Yountville Could Improve its Delivery of Medical Care

Chapter Summary

The health care industry defines the broad levels of services available in today's health care industry as a "continuum of care." The word continuum is meant to identify an interconnected group of inpatient, outpatient, and community-based health care entities that provide a progression of services based on decreasing patient needs. The goal of the continuum is to match patient needs with the least-costly setting to deliver the most appropriate care. In this chapter, we discuss some opportunities for the Veterans Home at Yountville (Yountville) to improve upon its continuum of care.

Yountville currently provides both nursing home care and hospital care to its resident veterans. Nursing home services are currently provided in a traditional institutional nursing home setting. We believe that the veterans and Yountville could benefit from the development of a home health agency that would provide nursing services in Yountville's residential settings. Providing home health care can increase the veterans' sense of independence and well-being, open up nursing home beds to veterans who need those services, and provide a source of reimbursements that Yountville is not currently utilizing.

We found that Yountville's provision of physician services deviates from standard industry practice. Specifically, Yountville employs physicians as staff rather than contracting for their services, as is typical in the industry.

Finally, we question the cost-effectiveness and benefits of operating a hospital at Yountville. We found that the costs of patient care, hospital support departments, and nursing staffing ratios are above statewide averages. Also, the clinical and operational skill sets required to provide high-quality hospital care are significantly different from that of a nursing home. Moreover, larger hospitals generally have a larger pool of expertise upon which to draw, are more likely to invest in newer technologies, and are more likely to train staff in the latest medical techniques than smaller hospitals such as Yountville's. These factors, taken into consideration along with

the low number of veterans served by the hospital and the opportunity for providing this service through local hospitals, suggest that continuation of hospital and surgical services may not be in the best interests of Yountville or the veterans.

Yountville Could Realize Improved Care, Increased Reimbursements, and Decreased Costs by Developing a Home Health Care Agency

Home health care would allow veterans to receive medical and social services in their residences rather than being moved to the nursing home.

Yountville currently provides skilled nursing and intermediate care in a traditional nursing home setting. We believe that Yountville could provide some of its nursing care in a residential setting. Within the industry, providing care in a residential setting is known as home health care and such care is provided by a home health agency. Home health agencies must be licensed by the State and are able to offer a wide range of care, including skilled nursing, therapy, and social services.

There are a number of benefits for both the veterans and Yountville in offering home health care. First and foremost, veterans could receive some of their medical and social services in their own residences on the Yountville campus rather than in the traditional nursing home setting. This could increase the veterans' sense of independence and well-being and could aid healing. Also, Yountville is currently not directly admitting veterans in need of skilled and intermediate nursing because all available beds are occupied. A home health services approach could open up skilled and intermediate nursing beds for those veterans who truly need them.

Home health care would also offer financial benefits to Yountville. Providing health care through a home health services arrangement is almost always less expensive than in an institutional setting when properly applied. Moreover, the development of home health services would add a new Medicare revenue source that is not currently being used.

Because Yountville lacks adequate clinical and financial data, we could not accurately calculate the financial impact of developing a home health agency. Nevertheless, we believe the potential for reducing costs, increasing reimbursements, and improving the quality of care is significant. In fact, Yountville had a license to provide home health services in fiscal year 1989-90. However, it never used its home health care license and has allowed it to expire. According to the acting chief medical officer, the license was allowed to expire due to lack of staffing and ancillary resources to meet changing licensing requirements.

The Cost-Effectiveness and Benefits of Operating a Hospital at Yountville are Questionable

The inpatient facilities of Yountville are divided into acute care, skilled nursing, and intermediate care. The skilled nursing and intermediate care facilities are commonly referred to as a "nursing home." Yountville's acute care facility is a 26-bed hospital that includes an intensive care unit and a general medical and surgical unit.

In general, hospitals as small as Yountville's are unusual because all hospitals are required by licensing regulations to have support department services. Examples of support departments include radiology, pharmacy, pathology, surgery, emergency, and 24-hour physician coverage. The fixed costs associated with these support departments often make operation of a small facility cost-prohibitive.

High costs of maintaining a small hospital are exacerbated by low utilization rates.

The high fixed costs of maintaining a small hospital at Yountville are further exacerbated by the fact that the hospital is underutilized. During fiscal year 1995-96, the hospital had an average daily census of only 11.7 patients for the 26-bed facility, which is approximately 45 percent of capacity.

The costs and the difficulties associated with operating a hospital raise questions regarding the cost-effectiveness of operating a hospital at Yountville versus using hospitals near Yountville. To address the questions of cost-effectiveness, we compared in Table 3 some key costs of Yountville's hospital to those of other small, for-profit and not-for-profit hospitals in the region.

As shown in Table 3, Yountville's costs per patient day for the intensive care unit and the medical/surgical unit are higher than the averages for other small hospitals in the region. However, based upon Yountville's inability to identify and accurately track actual costs by each department within the hospital, we believe that Yountville's costs per patient day may be even higher than estimated.

Table 3

Hospital Care Cost Comparisons Per Patient Day or Procedure

	All Facilities	*Not-for-Profit*	*For-Profit*	*Yountville*
ICU cost per patient day	$700	$807	$538	$715
Medical/surgical cost per patient day	242	252	196	260
Radiology expense per procedure	9.99	9.60	11.86	57.07
Pathology expense per procedure	1.38	1.10	2.17	18.08

Source: 1994-95 Office of Statewide Health Planning and Development hospital data base, volume one, which covers northern California for 24 hospitals from 16-87 beds.

It is highly unusual for a facility whose primary focus is nursing home and residential care to have on-site radiology and pathology services. Yountville's provision of hospital services requires it to have radiology and pathology services available either directly or through contractual agreement.

As illustrated in Table 3, the hospital's costs of these two support departments are markedly above state averages. Again, we suspect that the lack of cost-accounting systems has a significant impact on the accuracy of these figures. Nevertheless, according to Yountville's own data, the cost per radiology procedure is more than 6 times greater than the state average. Yountville's cost per pathology procedure is more than 13 times greater than the state average. These extraordinarily high costs per procedure are attributable to the relative low number of procedures performed at Yountville and the high costs of operating these departments.

Yountville's hospital costs per pathology procedures are 13 times greater and radiology services are 6 times greater than state averages.

Another factor that typically precludes a nursing home from operating a hospital is the fact that the clinical and operational skill sets required to provide high-quality care in a hospital are substantially different from that of a nursing home. Particularly in the area of intensive care services, all clinicians assigned to that area must have a high level of critical care skill sets and regularly use these skills to ensure proficiency. Moreover, larger hospitals generally have more specialists and a greater pool of expertise upon which to draw compared to a small

hospital such as Yountville's. Finally, larger hospitals are more likely to invest in new technologies and train staff in the latest medical techniques. These differences often affect the quality of services available at smaller hospitals.

Yountville already uses two area hospitals to provide services that are not reasonable to provide. The nearest—Queen of the Valley Hospital—is a 175-bed facility that provides all levels of high acuity and emergency patient services. It is approximately eight miles—a 10 to 15 minute drive—from Yountville. Yountville uses the Queen of the Valley Hospital for complex medical and surgical care, medical conditions that require significant physician specialist and diagnostic intervention, as well as specialized emergency services. The second hospital is the Veterans Administration Hospital in San Francisco, which is approximately 70 miles (two hours by car) away. Yountville uses the Veterans Administration Hospital in San Francisco for similar services. Only veterans with service-related conditions are eligible for a covered stay at the Veterans Administration Hospital in San Francisco.

During fiscal year 1995-96, veterans from Yountville were admitted to the hospital 874 times for inpatient services. However, 288 of those hospital admissions were to other area hospitals such as Queen of the Valley Hospital and the Veterans Administration Hospital in San Francisco. Therefore, 33 percent of the hospital admissions for Yountville's veterans are already being provided by other hospitals.

Yountville's own analysis reveals that its hospital costs exceed reimbursements by approximately $200 per patient day.

Because of the lack of clinical and financial data regarding the hospital, we could not accurately determine the fixed and variable costs of operating the hospital and associated departments. Moreover, we could not accurately determine whether the reimbursements generated by the hospital cover the costs of operation. However, Yountville has prepared its own analysis of hospital costs and reimbursements. It indicates that the hospital's costs exceed its reimbursements by approximately $200 per patient day. Based on the number of patient days incurred in 1995-96, this translates into a loss of $854,000 per year. It is important to note that we did not study or validate Yountville's analysis. We included its analysis in our report because it illustrates the potential financial burden of operating the hospital at Yountville.

In summary, the data suggests that the Yountville hospital and its support departments are not cost-effective. The hospital serves a relatively small percentage of the overall veteran population. Also, the support departments such as radiology, pathology, and pharmacy provide the majority of their services to veterans in nursing homes and residential areas outside the

hospital. The comparison of services and expertise available at larger hospitals near Yountville and the availability of outside contractors to provide services such as radiology and pathology raise the question of whether operating a small hospital is in the best interests of veterans, regardless of cost. The existence of these services may provide a level of convenience to veterans. Nevertheless, that convenience must be compared against the quality of care that can be provided, the availability of services in the nearby communities, and the cost-effectiveness of providing that care at Yountville.

Chapter 2

The Veterans Home at Yountville Can Reduce the Costs of its Medical Staff

Chapter Summary

The Veterans Home at Yountville (Yountville) employs 24 staff physicians to meet most of the veterans' medical needs. However, the more typical arrangement in industry is for the nursing home or the hospital to contract for physician services through independent physicians. We found that Yountville's use of staff physicians results in extraordinary physician costs that are not reimbursed by Medicare or Medi-Cal. During fiscal year 1994-95, Yountville incurred $2.8 million of direct physician expense while only generating $1 million in reimbursements for those physician services. The $1.8 million of unreimbursed physician expense could indicate either excess physicians on staff, low productivity among the physicians, or inadequate billing for the physicians' services. We analyzed the workload for the staff physicians assigned to the skilled and intermediate care areas. Based upon our analysis, we estimate that Yountville only needs five of its eight authorized positions. If Yountville reduced the number of physicians assigned to these areas by three full-time equivalent (FTE) positions, we estimate Yountville could save approximately $400,000 annually.

We also found that Yountville utilizes a greater percentage of costlier registered nurses (RNs) than the State average. The percentage of total direct care nursing hours from RNs is significantly above state averages and below state averages for licensed vocational nurses (LVNs) and nurses' aides (aides). We estimate that Yountville could realize a cost reduction in nursing of approximately $816,000 annually if the ratios of RNs, LVNs, and aides were consistent with statewide averages.

Finally, we noted that nurses' salaries at Yountville are significantly above state averages. We found that salaries for RNs and aides were above statewide averages by 13 percent and 72 percent, respectively. Salaries for LVNs at Yountville, by contrast, were 6 percent below the statewide average. Yountville could realize a cost reduction in nursing staffing of approximately $1.8 million if nursing salaries were consistent with statewide average salaries.

Physician Staffing Ratios Within the Nursing Home are Inconsistent With Statewide Benchmarks

Contrary to typical industry practices, Yountville staff physicians typically visit the wards and the veterans daily without consideration of patient need. This is unusual because a large portion of the intermediate care nursing home population primarily needs custodial care for activities of daily living such as eating, bathing, and dressing rather than medical care. Residents of skilled care nursing facilities are typically receiving nursing and rehabilitative services following their release from an acute care hospital or some other medical procedure. In either case, they do not need daily hospital care and the daily physician visits that are normal in hospital care.

Medicare regulations require physician visits at least every 30 days for skilled care level patients and every 90 days for intermediate care level patients. Patients can be seen in either setting as often as the physician deems necessary and skilled nursing patients will often be seen by a physician more than every 30 days and intermediate care patients once every 30 days.

Yountville's policy requires each physician to visit each assigned ward daily. While daily intervention may be appropriate in the hospital, nursing homes typically do not require this level of physician assessment. It is theoretically possible that a veteran at Yountville could be seen as often as daily by a physician in any nursing home setting. This potential level of physician interaction is significantly greater than the skilled nursing and intermediate care levels found in private industry. Many needs for physician interaction in private industry are addressed through telephone and facsimile communications between nursing personnel and the physician. The levels of care at Yountville do not indicate a highly complex medical need that would justify the high degree of direct medical interaction. Should patients need a higher level of medical interaction, they could easily be moved to the higher level of care or scheduled for more frequent physician visits.

The levels of care at Yountville do not indicate a highly complex medical need that would justify the high physician staffing ratios.

Based upon the current bed capacities within the skilled nursing and intermediate care facilities, we conclude that Yountville employs a greater number of staff physicians than necessary. We calculated the number of physicians needed using greater standards than those required by Medicare regulations. Our workload analysis assumed that physician visits in the skilled nursing facility would occur an average of twice a month rather than the Medicare minimum of once a month. We also assumed that veterans in the intermediate care area would need physician visits an average of once every 30 days rather than

once every 90 days as required by Medicare. This analysis does not assess the number of physician contacts that would take place through telephone and facsimile; this approach is implied as part of standard private physician practices. As shown in Table 4, we estimate that Yountville needs only five of its eight currently authorized positions to meet the medical needs for 316 skilled and 177 intermediate care beds. If Yountville reduced the number of physicians it employs in these facilities by three FTEs, it could save approximately $400,000 per year.

Table 4

Financial Impact of Primary Care Physician Benchmark

	Number of Beds	*Number of Visits Per Month*	*Estimated Number of Total Visits Per Month*	*Estimated Number of Visits Per Physician Per Month*[a]	*Number of Required Physicians (FTEs)*[b]	*Authorized Physicians (FTEs)*	*Variance*	*Estimated Savings*[c]
SNF	316	2	632	204	4	6	2	$268,000
ICF	177	1	177	204	1	2	1	134,000
Total								$402,000

[a]Industry standard—1995 Marion Merrell Dow Inc., Managed Care Digest.

[b]Calculated by dividing (number of total visits per month / visits by each physician per month) X 1.25 (75 percent productive).

[c]Calculated by multiplying variance X average physician salary plus benefits of $134,000.

The Employment Arrangements of Physicians At Yountville are Costly

Federal and state laws require that nursing homes such as Yountville have medical directors who oversee the policies and procedures that govern delivery of medical services. The typical arrangement in private industry is for medical directors to be paid an hourly rate based upon the number of hours devoted to medical director responsibilities. Any other services requiring physician interaction are done by either independent physicians, or the medical director, and billed to Medicare Part B directly by the physician.

However, as noted earlier, Yountville has chosen a model in which most of the physicians are salaried employees. As a result, Yountville is responsible for billing Medicare and obtaining the reimbursements for physician services. Coupled with this unusual arrangement is the fact that Yountville does not consistently use physician productivity measures or standards. The lack of incentives for physicians to prudently manage their time and expenses has contributed to a significant disparity between physician expenses and the reimbursements their billings generate.

$1.8 million in unreimbursed direct physician costs indicates either low productivity, excess physicians on staff, or inadequate billing.

During fiscal year 1994-95, Yountville incurred $2.8 million of direct physician salary expense in the ambulatory care, hospital, and surgical areas. That figure does not include the costs of physician benefits such as retirement, health insurance, malpractice insurance, vacation, and sick leave. During the same period, Yountville generated only $1 million in reimbursements for physician visits. The difference of $1.8 million in unreimbursed direct physician costs indicates either an excess of physicians on staff, low productivity among the staff physicians, inadequate billing of physician visits, or some combination of all three.

Yountville currently contracts with more than 20 private physicians in the community to provide specialty services. The proximity of Queen of the Valley Hospital indicates a large number of private physicians live in the Napa and Yountville areas. Yountville should consider privatization of all physician positions except those whose primary responsibility is to oversee the quality of medical services delivered at Yountville. These are the chief of ambulatory care and chief of medicine. Based on 1994-95 figures, privatization of all staff physicians except chief of medicine, chief of ambulatory care, chief of radiology, and chief of pathology would result in a decrease in revenue of $1 million and a decrease in expenses of $2 million, with a net positive cost reduction of $1 million.

Nursing Staffing Ratios Are Inconsistent With Statewide Benchmarks

The primary distinctions among RNs, LVNs, and aides are educational requirements and licenses that determine what services can and cannot be provided. RNs typically complete a two- to three-year education. LVNs typically complete a one- to two-year education. Aides complete a 60-hour certification class. Each level must pass a state-sponsored examination to practice nursing in California. Pay rates vary significantly by each level based on the education required and the skills each discipline provides.

Ratios of various levels of nursing care are measured by the number of highly trained nursing staff to lesser-skilled nursing staff appropriate for the patient care area being staffed. The services that each nursing category can provide are limited by law. RNs typically provide more complex nursing services and supervise other nursing personnel. LVNs provide more direct patient care and less technically complex services. Aides assist nursing personnel in direct patient care activities such as assisting veterans with activities of daily living. In California, LVNs are allowed to perform some technical tasks such as administration of intravenous (IV) fluids with additional training. However, the Yountville policies prohibit LVNs from administering IV fluids.

Table 5 shows that Yountville uses a significantly greater proportion of RNs than less costly LVNs and aides. Specifically, Yountville's skilled nursing area is staffed with 26 percent RNs, compared to the state average of only 10 percent. Therefore, Yountville uses 16 percent more RNs in its skilled nursing area than comparable facilities throughout the State. Conversely, Yountville uses 8 percent fewer LVNs and 8 percent fewer aides than comparable facilities throughout the State.

Table 5

Skilled Nursing Ratios

	All Facilities[a]	*For-Profit*[a]	*Nonprofit*[a]	*Government Owned*[a]	*Health Service Area Average*[a]	*Yountville 1994-95 Average SNF Ratio*[b]
RN	10%	12%	10%	5%	11%	26%
LVN	18	18	18	16	17	10
Aide	72	70	72	79	72	64

[a]Office of Statewide Health Planning and Development 1994-95 long-term care facility financial data base.
[b]1994-95 wages and salary supplement to the Governor's Budget for the State of California.

The higher-than-expected ratio of RNs might indicate an atypical need for professional skilled nursing services. However, the health levels of veterans cared for at Yountville do not exhibit higher-than-average need for skilled professional services.

By decreasing RN use and fully using the skills of LVNs and aides, Yountville can decrease costs significantly without reducing the amount of care the veteran receives. Table 6 illustrates the potential impact of changing Yountville's RN, LVN, and aide staffing ratios consistent with statewide averages.

Table 6

Financial Impact of Reallocating Nursing Hours

	Current Yountville Nursing Hours Allocation[a]	*Adjusted Nursing Hours Allocation*[b]	*Difference*	*Yountville 1994-95 Actual Average Hourly Rate*[a]	*Savings*[c]
RN	148,720	55,536	93,184	$20.48	$1,908,000
LVN	86,320	99,965	(13,645)	13.10	(179,000)
Aide	320,320	399,859	(79,539)	11.48	(913,000)
Total	**555,360**	**555,360**			**$816,000**

[a]1994-95 wage and salary supplement to the Governor's Budget for the State of California.
[b]Total nursing hours of 555,360 multiplied by the statewide average nursing ratios of 10 percent for RNs, 18 percent for LVNs, and 72 percent for aides.
[c]Difference multiplied by actual average hourly rate.

In this analysis, only the ratio in which nursing professionals are used is changed. The amount of daily care that a veteran would receive is not changed from current Yountville practices. Further, the care would continue to be provided by nursing staff appropriately trained to provide the level of care needed. We therefore estimate that Yountville could realize a cost reduction in nursing salaries of approximately $816,000 annually by shifting staffing ratios for RNs, LVNs, and aides to ranges consistent with state averages while maintaining the same level of care.

Nursing Salaries at Yountville are Inconsistent With State Benchmarks

Nursing salaries for RNs and aides at Yountville are higher than state averages, while salaries for LVNs are lower than state averages. As a result, we estimate that Yountville spends $1.8 million per year more in nursing salaries than it would if the salary rates were consistent with state averages.

Specifically, we found that Yountville aides are paid 72 percent more than statewide salary averages. RNs at Yountville are paid 13 percent more, while LVNs are paid 6 percent less than the statewide average.

Table 7

California Nursing Home Nurse Salary Averages

	Average Salary for All Facilities[a]	For-Profit[a]	Nonprofit[a]	Government Owned[a]	Health Service Area Average[a]	Yountville 1994-95 Average Rate[b]
RN	$18.13	$18.86	$18.61	$18.69	$18.41	$20.48
LVN	13.90	14.13	14.31	14.23	15.25	13.10
Aide	6.68	6.70	7.29	6.55	7.42	11.49

[a]Office of Statewide Health Planning and Development 1994-95 long-term care facility financial data base.

[b]1994-95 wage and salary supplement to the Governor's Budget for the State of California.

The duties and responsibilities identified in Yountville nursing job descriptions do not require different or more significant responsibilities than commonly found in the industry. The primary factor identified for the significant differences is the civil service pay classification and the length of employment associated with these positions. However, this does not fully explain why the RN and aide salaries are disproportionate when compared to other nursing facilities.

We calculated the financial impact of adjusting Yountville's nursing salaries to be consistent with state averages. Based upon the number of productive hours for each nursing level during fiscal year 1994-95, we estimate that Yountville could reduce its nursing costs by $1.8 million per year if the nursing

salary rates were consistent with state averages as illustrated in Table 8.

Table 8

Financial Impact of Nursing Salary Variance

	Average Salary for All Facilities[a]	*Yountville 1994-95 Estimated Average*[b]	*Variance*	*Total Productive Hours*[b]	*Impact*
RN	$18.13	$20.48	$2.35	148,720	$ 350,000
LVN	13.90	13.10	(.80)	86,320	(69,000)
Aide	6.68	11.48	4.80	320,320	1,538,000
Total				**555,360**	**$1,819,000**

[a]Office of Statewide Health Planning and Development 1994-95 long-term care facility financial data base.

[b]1994-95 wage and salary supplement to the Governor's Budget for the State of California.

Chapter 3

The Veterans Home at Yountville Does Not Maximize its Medicare and Medi-Cal Reimbursements

Chapter Summary

Maximizing Medicare and Medi-Cal reimbursements is key to the successful operation of most nursing homes in California. This requires careful tracking, recording, and reporting of the services provided and their corresponding costs. Medicare reimbursement rates vary by institution and are based upon their reported Medicare-eligible costs. Many nursing homes ensure they track and report all allowable costs and services by designating a small portion of their beds as a "certified distinct part" (CDP) for their Medicare-eligible skilled nursing patients. However, the Veterans Home at Yountville (Yountville) does not operate under this premise. Instead, Yountville has certified for Medicare reimbursement 294 of its 316 skilled nursing beds. This is despite the fact that Yountville experiences only enough Medicare-eligible skilled nursing days to fill eight beds on an annual basis. Because Yountville has certified such a large number of beds, it has combined the high costs of Medicare skilled nursing services with the lower costs of veterans receiving custodial care. As a result, Yountville receives a much lower reimbursement rate than it would receive if it tracked and reported the costs separately.

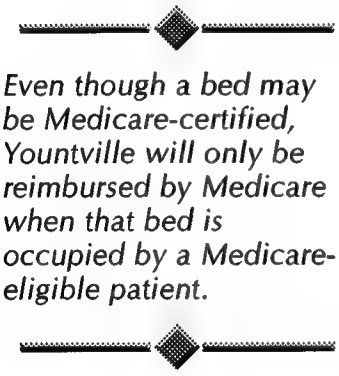
Another important technique for controlling costs and maximizing reimbursements is to ensure that patients are placed in the lowest level of care appropriate for their condition. Several observations during this review caused us to question whether Yountville is appropriately classifying the nursing needs of veterans. This issue is important because placing veterans in skilled nursing when they only need intermediate care is not only costly, but could be detrimental to their health and well-being.

Yountville is Not Maximizing its Medicare Reimbursements for Skilled Nursing

Medicare reimbursement rates vary from institution to institution. Medicare bases its reimbursement rate on each institution's actual cost of providing services. Medicare uses the cost data to establish a reimbursement rate of so many dollars per patient day.

Yountville can maximize its Medicare reimbursement rate by identifying and reporting only the costs of providing services to veterans receiving skilled nursing care as defined by Medicare. This approach is beneficial because Medicare-eligible and higher-skilled-level veterans have more serious medical needs than those in the general population who receive skilled nursing and intermediate care.

Serious medical conditions require a higher level of medical intervention and, therefore, require costlier services than the general population. Many facilities maximize their Medicare reimbursement rates by creating a CDP for Medicare-eligible skilled nursing patients within their institution. This allows the facility to more easily isolate, identify, and report all of the costs associated with providing skilled nursing services to its Medicare patients.



Even though a bed may be Medicare-certified, Yountville will only be reimbursed by Medicare when that bed is occupied by a Medicare-eligible patient.

However, contrary to common industry practice, Yountville does not operate under a CDP approach. Through our initial interviews, it became apparent that Yountville had fundamental misunderstandings about Medicare and its relation to licensing and reimbursement. The management of Yountville incorrectly believed that all 413 of its skilled nursing and intermediate care beds were certified for Medicare. According to the Department of Health Services (DHS), however, only 294 of Yountville's beds are actually Medicare certified. The management also incorrectly believed that its entire skilled nursing and intermediate care nursing facility needed to be Medicare certified in order to receive Medicare reimbursements. However, the DHS confirmed that Medicare regulations allow a facility to certify only a portion of their beds such as the CDP approach and that Medi-Cal reimbursement is not related to Medicare certification.

The problems with Yountville's Medicare certification of a large number of its beds are two-fold. First, even though a bed may be Medicare certified, Yountville will only be reimbursed by Medicare when that bed is occupied by a Medicare-eligible patient. We found that Yountville only provided 2,321 Medicare-eligible skilled patient days during fiscal year

1995-96, which is equal to approximately eight skilled beds annually.

The second problem with Yountville's approach is that by including all beds in its Medicare cost pool, Yountville has combined the high costs of providing services to Medicare-eligible skilled level patients with the lower costs of providing services to veterans who require long-term custodial-type care, thus diluting its average cost per patient day. As a result, Yountville's Medicare reimbursement rate is far lower by including the entire population than it would be if the rate were based only on Medicare-eligible services under a Medicare CDP.

Medicare reimbursement is made up of the two primary components of routine and ancillary costs. Examples of routine costs include nursing, normal supplies, dietary, and facilities. Ancillary costs include physical therapy, occupational therapy, and speech therapy. Routine costs are limited by Medicare regulations. Well managed institutions, therefore, try to keep their actual routine costs at or below the Medicare limits. On the other hand, ancillary costs are not limited by Medicare regulations. Institutions therefore try to maximize the allowable costs included in their ancillary component of their costs.

We found that Yountville's Medicare reimbursement is only $8 per patient day for ancillary therapy while other facilities approach $100 per patient day for these services.

We found that the ancillary cost component of Yountville's Medicare reimbursement rate is very low compared to what we typically find in the industry. Specifically, we found that Yountville's Medicare reimbursement rate included only $8 per patient day in ancillary services cost. This indicates very low ancillary use for such a large Medicare-certified area and the potential for ancillary therapy utilization. In our experience, it is not uncommon for facilities using a CDP approach to have ancillary therapy costs of $100 per patient day contributing to their Medicare reimbursement rate.

Because of a lack of cost data for Medicare patients at Yountville, we cannot accurately calculate the effect that an appropriately sized CDP might have on Yountville's Medicare reimbursement rate. However, based upon our extensive experience with this type of arrangement at other facilities, we are confident that improvements in identifying and reporting only the costs of veterans meeting Medicare skilled level care criteria at Yountville will significantly increase Yountville's Medicare reimbursement rate.

Yountville's Use of Skilled Nursing Beds is Inconsistent With Industry Practice

California has distinct licensing requirements for skilled nursing and intermediate care beds. According to the California Code of Regulations, beds licensed as skilled nursing in the State must meet a minimum staffing level of 3.0 labor hours per patient day. In addition, a registered nurse must be present a minimum of eight hours per day, seven days per week. Intermediate care nursing facilities are required to maintain a minimum staffing level rate of 1.1 labor hours per patient day and must have registered or licensed vocational nurse coverage eight hours per day, seven days per week.

Because of the different staffing level requirements between skilled and intermediate care areas, the costs of staffing and maintaining skilled nursing beds are significantly higher than those of intermediate nursing care beds. In addition, each level of care has distinct levels of reimbursement by the Medi-Cal program. For example, the daily reimbursement rate in Yountville, effective August 1996, is $194.74 for skilled nursing, while the daily reimbursement rate for intermediate care is only $73.04. It is important to note that Yountville does not automatically receive the higher skilled nursing reimbursement rate for a veteran who happens to occupy a skilled nursing licensed bed. Rather, Yountville will only be reimbursed at the higher skilled nursing rate if the veteran meets the clinical definition for skilled care, meets the financial needs eligibility criteria, and is occupying a bed licensed for skilled nursing care.

Only 14,600 of the 113,000 skilled care patient days were reimbursed by Medicare and Medi-Cal.

Yountville has many more skilled nursing beds than intermediate care beds, which is unusual within the nursing home industry. Specifically, Yountville has 316 skilled nursing beds and only 177 intermediate care beds. Also, contrary to nursing home industry norms, the majority of veterans in the skilled nursing beds are not reimbursed by Medicare. In addition, according to Yountville, most of its veterans are ineligible for Medi-Cal. Based upon a review of Yountville's patient data for fiscal year 1995-96, we found that of a total of 113,000 skilled care patient days, Yountville only experienced approximately 2,300 patient days that were reimbursed by Medicare and 12,300 patient days that were reimbursed by Medi-Cal. The remaining 98,000 patient days were not reimbursed by either Medicare or Medi-Cal.

The large number of unreimbursed skilled patient days raises at least two questions. First, is Yountville properly classifying the level of care needed by the veterans as skilled or intermediate? Second, is Yountville identifying and claiming reimbursement

for all of the veterans receiving skilled care who are eligible for Medicare or Medi-Cal?

Nursing homes typically do not experience significant numbers of patients who would require long-term skilled level care that is not reimbursable by Medicare or Medi-Cal. Veterans requiring long-term care for custodial needs support and medical observation make up the majority of veterans in the skilled care area. Because these patients do not meet the skilled and rehabilitative needs defined by Medicare, they are not eligible for Medicare reimbursement. According to Yountville, the patients in the skilled nursing facility were classified using the Medi-Cal criteria. Yountville officials stated that they do not receive more Medi-Cal reimbursements because a large number of veterans do not meet the financial needs criteria to be eligible for Medi-Cal.

Reclassifying half of its skilled nursing beds to a level above intermediate care could save $1 million annually.

The question of whether Yountville is properly classifying the level of care needed for the veterans in its facility is significant because it has important financial and quality of care implications. For example, if Yountville could reclassify half of its current 316 skilled care beds to a lower level of care, we estimate that Yountville could save approximately $1 million annually. Specifically, we assumed for the purposes of our analysis that Yountville needs only 156 skilled beds with a minimum staffing level of 3.0 labor hours per patient day. We further assume that the remaining 155 beds would be licensed as intermediate care and require 2.0 labor hours per patient day. This staffing level is in between the minimum staffing requirements for skilled care of 3.0 and intermediate care of 1.1 labor hours per patient day. Based upon these assumptions, we estimate that this reclassification of skilled nursing beds would result in a reduction of 85,000 labor hours per year. That translates into a reduction of approximately 40 nursing staff full-time equivalents, or approximately $1 million per year.

It is important to note that we do not know whether Yountville is properly classifying the needs of the veterans in its facilities. We therefore do not know whether Yountville could reclassify some of its skilled nursing beds and achieve some savings. Nevertheless, we provided the preceding example to illustrate the point that proper classification of the veterans' needs has significant financial implications for Yountville and warrants further attention.

Another issue that causes us to question Yountville's classification of its patients or its ability to capture Medicare patient days is the number of veterans discharged from the hospital. Medicare regulations provide for a certain number of

reimbursable skilled nursing care days after release from a hospital stay of three consecutive days or more. Normally, one would expect to see a correlation between the number of hospital discharges and the number of Medicare reimbursed skilled patient days. However, Yountville's Medicare reimbursed skilled patient days are very low compared to the number of hospital discharges.

While one might assume that placement in a skilled nursing facility that has a higher level of staffing and medical intervention would improve the quality of care provided to the veterans, this is not necessarily always the case. A veteran whose condition only warrants placement in an intermediate care area but who is instead placed in skilled nursing could receive more medical intervention than needed and less direct care than required. Patients who truly need skilled care require more hours of direct care. When patients of intermediate needs are mixed with skilled needs patients, the needs of higher acuity skilled patients tend to outweigh the needs of lesser acuity intermediate patients. Therefore, intermediate care patients can actually receive less care in a more highly staffed area. In addition, a veteran may receive more diagnostic procedures than might otherwise be performed in an intermediate care setting. These procedures can be painful and disruptive for the veteran and lead to other complications.

The philosophy of most health care providers is to place the patient in the setting most appropriate for their condition and provide medical intervention only when necessary.

In addition, veterans needing only intermediate care who are placed among those who truly need skilled care expose intermediate level veterans to more serious ailments and conditions. Such exposure could also prove to be detrimental to the veterans' health and well-being. The philosophy of most health care providers and professionals today is to place patients in a setting appropriate for their condition and provide medical intervention only when necessary. Such a philosophy should provide the most independence and highest quality of life. Therefore, the proper classification of the veterans' medical needs is not only important in terms of reimbursements, but is also important to the quality of care provided to veterans and to their quality of life.

Finally, we noted that the skilled nursing beds are scattered in two locations throughout the nursing home campus. We believe this is inefficient. The best configurations are those where all skilled beds are located in a common area that allows for a concentration of nursing staff and physician services. This allows for efficient tracking of costs for veterans needing skilled care. Further, separating veterans in skilled nursing who need high-level services from those in intermediate care who are trying to achieve more independence will provide a better environment for both groups.

Chapter 4

The Veterans Home at Yountville Needs to Improve its Management Information System and Could Reduce Some Costs Through Outsourcing

Chapter Summary

Throughout this audit report, we indicated that the Veterans Home at Yountville's (Yountville) lack of adequate financial and clinical data prevented us from completing a more thorough review or analysis on a wide variety of topics. That same lack of data also prevents the management at Yountville from using many of the common management techniques employed by their counterparts in the industry. The lack of adequate financial and clinical data is the result of poorly designed, outdated, or nonexistent systems.

Many private nursing homes as well as the California Veterans Home at Barstow (Barstow) and other states' veterans' homes outsource key cost areas. Departments such as laundry, dietary, and housekeeping often represent significant costs to the facility that can be easily outsourced while improving the overall quality. We compared Yountville's costs of laundry and dietary services to those of Barstow, which are provided by outside contractors. Based upon those comparisons, we estimate Yountville could save approximately $2 million annually by contracting for dietary services and approximately $350,000 annually by contracting for laundry services.

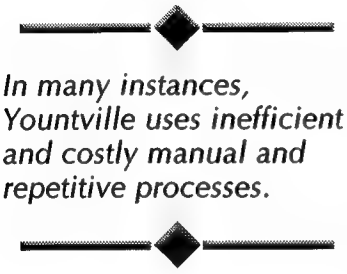
Yountville's Management Information Systems are Inadequate

Management information systems (MIS) are at the heart of efficient operations in the private sector. The health care MIS hardware and software that exist in the marketplace can assist in the efficient tracking, monitoring, billing, and management of key resources within Yountville. Key to the capabilities of an efficient MIS is the ability to attach costs, reimbursement, and utilization data to the patient, unit, department, and facility.

The ability to monitor, track, and manage human resources on a timely basis is essential to facilities operating in managed care

environments. This information provides management with the ability to shift human resources based on needs of patients on an as-needed basis as opposed to weeks and months after the fact.

Yountville's current MIS does not allow for efficient reporting and tracking of typical MIS data. Yountville could use personal computers as an interim solution to monitor and manage some key reimbursement and cost components. However, a fully functional MIS should be implemented to gain maximum efficiency.



In many instances, Yountville uses inefficient and costly manual and repetitive processes.

In many instances, Yountville uses manual and repetitive processes that are inefficient and costly. Employee time tracking is one such area. The typical process is that employees sign a form at their respective departments each workday. This form is sent to data entry, where employees' times are keyed into the payroll system. Regardless of where employees actually work on a particular day, their hours are recorded under the department to which they normally report. This creates significant inaccuracy potential when attempting to analyze labor utilization practices because Yountville, like most institutions, moves its staff where they are needed most. In addition, the manual nature of the process creates significant inefficiencies, costs, and decreased time responsiveness.

Data tracking charges for services and supplies is also significantly deficient. Management of various charge-generating departments such as pharmacy, central supply, radiology, pathology, and ancillary services do not have credible data to track the amount of supplies or services billed or delivered. Nor can management track the utilization and revenue generated by department or unit. Tracking lost charges is a key process that nursing homes and hospitals routinely perform to identify weaknesses and opportunities and to ensure full reimbursement.

We found that once supplies or services are delivered to a unit within Yountville, management does not know whether the supplies aid veterans and what the associated revenues are for the particular supply item or service. Department managers said that reports providing information or understanding of the revenues generated by their department's activity are not available. Also, managers did not know whether their departments were cost-efficient relative to revenue generated. In central supply, managers do not have information showing whether all supplies delivered to a particular area are used for veterans and billed to a payer.

Lastly, the lack of an MIS is at the heart of Yountville's inability to produce financial statements and cost-accounting information typical in the nursing home and hospital industries. Cost management is a fundamental component to operating in a managed care environment. Yountville's current system is deficient in producing reports that are necessary to assess its financial performance organization-wide and by department. At a minimum, Yountville should be able to produce the following information by unit, department, and facility:

- Balance sheets
- Profit and loss statements
- Accounts payable
- Accounts receivable
- Revenue
- Expenses
- Payer mix
- Labor cost

The effect of the MIS deficiency is that significant opportunities for revenue maximization and cost reduction exist within Yountville. However, this potential cannot be accurately estimated or realized because of the lack of the very data a good MIS would provide.

According to the California Department of Veterans Affairs (DVA), a comprehensive MIS is being developed and implemented at Barstow. The DVA hopes to duplicate that system at Yountville when it is complete. The DVA's contract for the Barstow MIS includes a fixed price for the hardware and software needed for Yountville. The DVA also requested an additional $550,000 through the 1997-98 Governor's Budget for the wiring needed for Yountville's MIS. The DVA said it is ready to begin implementing the MIS at Yountville upon legislative and Department of Finance approval and funding. However, we did not review the Barstow system. We therefore cannot conclude whether it will meet Yountville's needs.

Yountville Could Realize Significant Cost Reductions Through Outsourcing of Laundry and Dietary Services

Outsourcing of key nursing home cost areas is common in the industry. Departments such as laundry, dietary, and housekeeping often represent significant costs to a facility's operations and can easily be outsourced while improving the overall quality of service. Companies specializing in these

services can provide them to nursing homes at significantly lower costs than Yountville.

Laundry and dietary costs accounted for 16.5 percent of Yountville's total expenses for the three-month period ended June 30, 1996. We compared Yountville's costs to nursing home facility data gathered from the Office of Statewide Health Planning and Development for the same time period. These comparisons are illustrated in Table 9.

Table 9

Dietary and Laundry Cost Per Patient Day

	All Facilities[a]	*Not-for-Profit*[a]	*For-Profit*[a]	*Yountville*[b]
Laundry costs per patient day	$2.26	$2.61	$2.21	$3.92
Dietary cost per patient day	9.72	13.30	9.25	15.62

[a]Office of Statewide Health Planning and Development 1994-95 long-term care facility financial data base.

[b]Total laundry and dietary costs from the 1994-95 cost report were multiplied by the percentage of laundry pounds and dietary meals, respectively, related to the SNF and ICF units to determine the total SNF and ICF costs. The total SNF and ICF costs were then divided by the total SNF and ICF patient days to determine the costs per patient day.

Specifically, we found that Yountville's laundry costs per patient day are 73 percent higher than the statewide average. In addition, Yountville's dietary costs per patient day are 61 percent higher than the statewide average.

Barstow currently outsources its laundry and dietary services, among others. We compared the cost of services in the Barstow contracts to those of Yountville. Our comparison takes into account the responsibilities of the facility and the contractor as well as what costs the facility incurs as part of the contract agreement.

The Barstow dietary services contract stipulates that the contractor will provide all food purchasing, employees, management, and menu services. The Barstow facility is responsible for equipment and kitchen costs. Yountville served approximately one million meals in 1995. If Yountville was

allowed to contract out dietary services under a similar arrangement as the Barstow facility, it would realize approximately $2 million in cost savings associated with dietary services as illustrated in Table 10.

Yountville's laundry area is significantly compromised by the age and inefficiency of the capital equipment and cost of labor. In order for Yountville to continue providing this service directly, significant investments in equipment would have to be made. One of the compelling factors in contracting this service out is the elimination of the equipment costs, maintenance, and the frequent need to purchase linen. In contrast, as shown in Table 10, the Barstow facility outsources its laundry services and pays significantly less. We estimate that Yountville could realize a cost reduction potential of approximately $350,000 annually if laundry services were outsourced under arrangements similar to Barstow.

Table 10

Annual Dietary and Laundry Outsourcing Cost Savings

	Yountville[a]	*Barstow*	*Variance*	*Cost Savings*[b]
Laundry costs per patient day	$2.14	$1.26	$2.66	$ 350,000
Dietary costs per meal	5.16	3.28	1.88	2,000,000

[a]Costs per patient day for entire facility.

[b]Cost savings calculated by variance x patient days.

Chapter 5

Conclusions and Recommendations

The Veterans Home at Yountville (Yountville) is a complex organization facing a number of challenges. The management of Yountville has made some improvements since our last audit in 1994. However, significant opportunities for improvement remain. The following pages are a summary of our findings and the detailed recommendations corresponding to those findings.

Home Health Agency

We found Yountville is providing all of its intermediate and skilled nursing care in an institutional setting. However, we believe that Yountville can better serve its residents by providing an additional level of nursing care in its residential and domiciliary areas. A home health agency is simply a licensed unit that would provide the same type of services that the veterans now receive in the intermediate or skilled nursing areas of Yountville but in their own residences.

Providing home health services offers a number of advantages for the veterans and Yountville including:

- Increasing the veterans' sense of independence and well-being by allowing them to stay in or return to their own residences;
- opening up intermediate and skilled nursing beds in Yountville to veterans who cannot currently access those services;
- decreasing the cost of services; and
- creating a new source of Medicare revenues that Yountville is not currently utilizing.

Recommendation

Yountville should renew its expired license for home health care and provide services to veterans in their residential settings whenever medically appropriate and cost-effective.

Physician Resources

We noted a number of deviations from standard industry practices regarding physicians. Specifically, Yountville has physicians on staff rather than the more common method of contracting on a fee-for-service basis. Also, we believe Yountville employs more staff physicians than necessary or appropriate. Because of either excess physicians on staff, low productivity among the physicians, or inadequate billing for physician visits, Yountville incurs more than $1.8 million in unreimbursed physician costs annually.

Recommendations

Yountville should consider one of two alternatives for delivering physician services:

Alternative 1

If Yountville decides to continue to retain physicians as employees, we recommend, at a minimum, that it take the following actions:

- Reduce the number of physicians in its inpatient facilities. According to our analysis, we estimate that Yountville only needs five of the eight physicians currently assigned to the inpatient care areas. Reduction of physician staff could be accomplished through attrition or relocation.

- Yountville should review all its outpatient functions to determine the appropriate physician staffing levels and reduce staff where appropriate.

- Develop productivity standards and performance measures for all staff physicians.

- Develop tracking and billing systems to ensure that all physician visits are billed and reimbursed to the maximum extent possible.

Alternative 2

Eliminate staff physician positions at Yountville and contract for physician services from the local medical community. The physicians should be retained on a fee-for-service basis in which they bill Medicare and Medi-Cal directly for their services. Yountville should retain as staff physicians the chiefs of medicine and ambulatory care to oversee the quality of care provided by the private physicians. This alternative could be accomplished through a variety of techniques such as joining a local HMO or creating an independent private practice group. However, Yountville would need to ensure that such an approach would provide a sufficient number of physicians meeting its quality standards.

Hospital and Surgical Services

In addition to the nursing home services provided by Yountville, it also operates a hospital with an intensive care unit, surgical unit, emergency room services, and all of the support departments such as radiology and pathology that are necessary for a licensed hospital. However, the small size of Yountville's hospital and its low utilization rates suggest that the hospital is not cost-effective. Yountville's own analysis indicates that the hospital's costs exceed its reimbursements by approximately $200 per patient day. That translates into a loss of $854,000 for fiscal year 1995-96.

We also found that the hospital's costs for some of its support departments are far greater than those found within the industry. For example, radiology costs per procedure are 6 times greater than statewide averages and pathology costs are 13 times greater than statewide averages. Finally, we question the quality of care provided at an unusually small hospital such as Yountville's versus the quality of care that can be obtained at nearby larger hospitals with more specialists and a greater pool of expertise.

Yountville does not have sufficient financial and clinical data to allow us to conduct a comprehensive cost-benefit analysis of hospitals at this time. However, the anecdotal information we gathered through our brief review strongly suggests that the hospital is not cost-beneficial.

Recommendations

To ensure veterans receive hospital services in the most appropriate setting, Yountville and/or the Legislature should consider the following alternatives for providing hospital services:

Alternative 1

Should Yountville choose to continue operating the hospital, we recommend the following actions:

- The Legislature should require a comprehensive study of the costs and benefits of continuing the operation of Yountville's hospital versus obtaining hospital services from the local medical community. This study should assess the quality of care delivered to the veterans under both alternatives.

- Yountville should continue to explore the possibility of offering hospital services to local veterans to increase the hospital's utilization rate.

- The Legislature should consider requiring Yountville to bring both its hospital costs per patient day and support department costs in line with industry averages within a reasonable period of time.

Alternative 2

Discontinue the operation of the hospital at Yountville. Yountville should contract for all needed hospital services through the local medical community on a fee-for-service basis. Adoption of such a recommendation would relieve Yountville of the responsibility for tracking and billing Medicare and Medi-Cal for hospital services. Instead, the hospitals and doctors providing the care would assume that responsibility. The beds and space previously utilized by the hospital could then be converted to use for its nursing home function. Yountville would need to ensure that such an approach would provide a sufficient amount of hospital services meeting their quality of care standards.

Nursing Resources

We found that Yountville uses a higher-than-industry-average ratio of registered nurses (RNs) compared to the less costly licensed vocational nurses (LVNs), and nurses' aides (aides). We estimate that Yountville could save approximately $816,000 annually by shifting staffing ratios for RNs, LVNs, and aides to ranges consistent with statewide averages without decreasing the amount of direct nursing care received by the veterans.

Recommendations

To ensure that it efficiently utilizes its nursing resources, Yountville should take the following actions:

- Eliminate to the maximum extent allowable under law, any unnecessary internal policies and procedures that preclude the utilization of LVNs and aides.

- Adjust the nursing staffing ratios to be more consistent with industry averages by increasing utilization of LVNs and aides.

We also noted in our report that nursing salaries at Yountville differed significantly from comparable salaries in the nursing industry. We recognize that the collective bargaining agreements that establish the nurses' salaries are statewide and are negotiated by the Department of Personnel Administration (DPA) and the nurses' unions. Yountville, therefore, has little opportunity to influence the salary rates of its nursing staff. However, we will forward our findings to the DPA and recommend that it consider them when negotiating the nurses' contracts.

Maximizing Medicare Reimbursements

Many facilities maximize their Medicare reimbursement rates by creating a "certified distinct part" (CDP) within their institution. This allows facilities to isolate and report all costs associated with providing skilled nursing care to Medicare-eligible patients. However, contrary to industry practice, Yountville has certified most of its 316 skilled nursing beds for Medicare. We found that Yountville only provided 2,321 Medicare-eligible skilled nursing patient days during fiscal year 1995-96, which is equal to approximately eight skilled nursing beds annually. As a result, Yountville's Medicare reimbursement rate is far lower

than it would be if the rate were based upon costs captured in an appropriately sized and monitored CDP.

We also found that some of the medical and administrative staff of Yountville lacked the expertise in Medicare and Medi-Cal reimbursement techniques typically found in their counterparts in the industry. Moreover, we found that neither the physicians nor support department staff had the information or incentive to determine whether they generated sufficient reimbursements to cover their costs.

Recommendations

To ensure it maximizes Medicare reimbursement, Yountville should take the following actions:

- Create a CDP system within its skilled nursing facility commensurate with the size of its Medicare-eligible population;

- ensure that it is properly tracking and recording all costs of services provided within the CDP; and

- require the appropriate medical and administrative staff to attend training on Medicare and Medi-Cal reimbursement regulations to improve their awareness of these issues.

Utilization of Skilled Nursing Care

A number of issues that came to our attention during this review caused us to question whether Yountville is appropriately using skilled nursing care. For example, we found that inconsistent with industry norms, 98,000 (87 percent) of Yountville's total skilled nursing days during 1995-96 were not reimbursed by either Medicare or Medi-Cal. In addition, we noticed an unusual inconsistency in discharges from the hospital versus Medicare reimbursed skilled nursing days.

The Yountville management properly points out that many of the veterans who might eventually qualify for Medi-Cal reimbursement at private nursing homes do not do so while at Yountville. Moreover, the management said that it uses Medi-Cal regulations in evaluating the veterans' needs for nursing care. However, we were unable to perform the type of study needed to determine whether the veterans are placed in the appropriate level of care as a part of this review. Nevertheless, we believe this issue warrants further

consideration because it has significant financial implications for Yountville. Moreover, placing veterans in skilled nursing care when they are only in need of intermediate care can adversely affect the veterans and their quality of life.

We also noted that skilled nursing care was provided at two different locations at Yountville. We believe that such a configuration is inefficient. The best configurations have all skilled nursing beds in a common area. This allows for concentration of nursing staff, physician services, and efficient tracking of costs. Furthermore, separating veterans in skilled nursing who need high-level services from those in intermediate care who are trying to achieve more independence will provide a better environment for both groups.

Recommendations

To ensure that veterans receive the appropriate level of nursing care in the most appropriate setting, we recommend the following actions:

- The Legislature should consider requiring a study of veterans receiving skilled and intermediate care at Yountville to determine whether the veterans are placed in the appropriate level of care. This study is known as a "clinical acuity study," which is performed by clinicians with experience performing this type of specialized medical assessment. This study should also determine whether Yountville is receiving all of the Medicare and Medi-Cal reimbursements for these services to which it is entitled.

- Yountville should provide all skilled nursing services in one common area and separate skilled nursing from intermediate care veterans.

Management Information Systems

Throughout this audit, we noted numerous weaknesses resulting from Yountville's lack of an adequate management information system (MIS). Many of these same weaknesses were identified in the 1994 audit of Yountville. According to the California Department of Veterans Affairs (DVA), a comprehensive MIS is being developed and implemented at the Veterans Home in Barstow (Barstow). The DVA hopes to transfer and use the same system in Yountville when it is completed.

A review of the MIS at Barstow was not within the scope of this review. Therefore, we could not determine whether the Barstow system will address Yountville's needs. Nevertheless, the lack of an adequate MIS effectively precludes Yountville from utilizing many of the management techniques commonly used by the industry. In essence, Yountville does not have the tools it needs to adequately control costs and maximize reimbursements.

Recommendations

To ensure management has the information it needs to properly and efficiently manage the medical operations at Yountville, we recommend it take the following actions:

- Make the development of an MIS a top priority.

- Explore interim solutions for its MIS. We are concerned that the time and expense of developing a comprehensive solution or transferring the Barstow system will delay implementation for an extended period of time. If so, interim solutions should be considered. There are a wide range of relatively inexpensive personal computer-based software packages available that will perform many of the basic functions needed by Yountville.

- In the absence of viable interim solutions, we recommend that Yountville develop and utilize manual procedures to identify and record vital management information until automated solutions are developed.

Outsourcing Dietary and Laundry Services

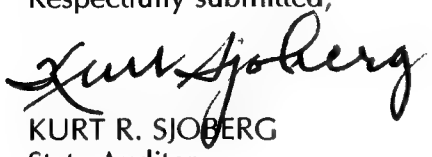
We compared Yountville's costs of laundry and dietary services to those of Barstow, which are provided by outside contractors. Based upon those comparisons, we estimate Yountville could save approximately $2 million annually by contracting for dietary services and approximately $350,000 annually by contracting for laundry services.

Recommendation

Yountville should outsource its laundry and dietary services using the same type of contractual arrangement as Barstow.

We conducted this review under the authority vested in the state auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope of this report.

Respectfully submitted,



KURT R. SJOBERG
State Auditor

Date: January 29, 1997

Appendix A

Follow-Up of Previous Audit

In April 1994, the Bureau of State Audits released audit report 93027 titled *"The Veterans Home of California Has Not Maximized Revenue From Residents and Reimbursements From the Federal Government."*

This audit was required by the 1993-94 Budget Act, which called for a review of the policies and procedures of the California Department of Veterans Affairs (DVA) to maximize fees paid by residents of the Veterans Home at Yountville (Yountville). The Budget Act also called for an evaluation of the DVA's efforts to maximize all sources of reimbursements from both the residents and the federal government. The following is a summary of the major findings and recommendations of that audit along with our comments regarding any corrective actions taken by the DVA and Yountville in response to our findings and recommendations.

Finding #1: By not implementing adequate procedures and adopting policies to recover all possible fees, Yountville has not maximized revenue from residents. For example, Yountville can increase reimbursement if it assesses an estimated $150,000 annually in fees on some Social Security income received by residents and charges residents an additional $1 million annually by raising fees to the maximum allowed by the Budget Act.

We recommended the DVA continue to assess and collect fees on the Social Security income it reimburses residents for Medicare premiums. Also, the DVA should raise residents' fees to the maximum allowed by the Budget Act, assuring that residents do not pay more than the state-funded cost of their care. Finally, the DVA should consistently verify income information from the residents.

Department Action: Corrective action taken.

Yountville implemented the assessment of fees on supplemental Social Security income effective March 1, 1994. Yountville additionally supported legislation (AB 3635), signed by Governor Wilson on July 20, 1994, which raised fees and charges and, in fiscal year 1995-96, generated fees in excess of $1.7 million over

the 1993-94 levels. The DVA also says that it currently verifies pension income with Social Security and the U.S. Department of Veterans Affairs and requires members to submit copies of income tax returns and bank statements, but has no legal authority to review all income sources of members of Yountville.

Finding #2: Although Yountville has the statutory authority to collect the state-funded cost of care from the estates of residents who remain at Yountville until death, it does not have the authority to collect from residents who leave Yountville to live somewhere else. For example, the state-funded cost of care provided to the approximately 100 residents who left Yountville in 1993 would have been approximately $787,000 if they had resided in Yountville for only one year and had received domiciliary care, the least costly level of care. The amount Yountville might have recovered depends on the income and assets of the residents who left Yountville. Because of the inconsistency in the law, Yountville could not collect any portion of these costs from the former residents or even their estates upon their deaths.

We recommended the DVA seek statutory authority to collect the state-funded cost of care from residents who leave Yountville to live somewhere else.

Department Action: None.

The DVA says this recommendation would not be cost-effective to implement because of the generally low-income level of Yountville membership and the impracticality of collecting from former members; only a limited return could be expected from costly efforts.

Finding #3: By not implementing adequate procedures to recover all possible reimbursements, Yountville has not maximized reimbursements from the federal government. We reviewed Yountville's reimbursements in fiscal year 1992-93 and found that Yountville received $260,000 less in Medicare reimbursements for hospital care than it would have if it had been reimbursed at rates similar to comparable institutions. In addition, Yountville received $200,000 less in reimbursements for outpatient clinic visits than it would have if it had received reimbursements for the percentage of residents who were eligible for Medicare. Also, Yountville received approximately $293,000 less in reimbursements than possible for certain therapy services.

Yountville received less in these reimbursements because its manual procedures and automated systems do not adequately accumulate all the possible charges to Medicare, do not properly classify all the charges by complexity, and do not properly price all the charges.

We recommended the DVA develop an action plan for improving manual procedures that will capture all patient care charges. Also, the DVA should continue analyzing and procuring a cost-effective management information system capable of supporting all aspects of Yountville's activities, including patient care, reimbursements, and general management information beneficial to the overall cost-efficient management of Yountville.

Department Action: Partial corrective action taken/ pending.

The DVA evaluated all operations related to reimbursement collection and identified goals to more efficiently and effectively maximize reimbursements. The DVA also created a reimbursement task force to perfect procedures and achieve the most reimbursement allowed. As a result, in fiscal year 1995-96, Yountville generated Medicare reimbursements in excess of $1.3 million over the 1993-94 levels. As we discuss in Chapter 4 of this report, Yountville has taken some corrective action but continues to have significant weaknesses in its management information system. Specifically, the DVA is developing a comprehensive management information system for the Veterans Home at Barstow, which it hopes to transfer to Yountville when completed.

Finding #4: Yountville could have received up to approximately $446,000 annually in aid and attendance allowances if the federal Department of Veterans Affairs determined that 95 residents had been eligible to receive the allowances and if Yountville had obtained the statutory authority to receive the allowance for all veterans, including those with dependents.

We recommended that the DVA continue to develop procedures to ensure that aid and attendance allowances are received for all eligible residents. We also recommended that the DVA seek legislation allowing Yountville to receive aid and attendance allowances for residents with dependents who do not provide regular assistance to the residents.

Department Action: Corrective action taken/pending.

Yountville has implemented procedures to ensure that all resident veterans are given assistance in applying for all benefits, including aid and attendance, from the federal Veterans Administration. In addition, the DVA established an aid and attendance task force to review Yountville's procedures for receiving aid and attendance. As a result, in fiscal year 1995-96, Yountville received aid and attendance allowances in excess of $465,000 over the 1993-94 levels.

The DVA agrees with the second part of the recommendation and will continue to explore this matter and review the options that would allow Yountville to collect all aid and attendance allowances paid to home members, including residents with dependents who do not provide regular assistance to the residents.

STATE OF CALIFORNIA PETE WILSON, Governor

DEPARTMENT OF VETERANS AFFAIRS
POST OFFICE BOX 942895
SACRAMENTO, CALIFORNIA 94295-0001
(916) 653-2158

January 24, 1997

Kurt R. Sjoberg
State Auditor
Bureau of State Audits
660 J Street, Suite 300
Sacramento, CA 95814

SUBJECT: RESPONSE TO THE REPORT ON THE VETERANS HOME OF CALIFORNIA BY THE STATE AUDITOR

Dear Mr. Sjoberg:

Thank you for the audit report on the Veterans Home of California (Home), conducted by Ernst and Young LLP, entitled, "California Department of Veterans Affairs: The Veterans Home of California Could Decrease Costs, Increase Revenues, and Improve the Quality of Care Provided to Its Residents by Utilizing Accepted Industry and Managed Care Techniques." The Home welcomes the audit and believes that many of the findings and recommendations contained in the report can assist the Home in improving its medical operations to become more cost effective and efficient. In particular, the recommendation of the auditors emphasizing the importance of the implementation of a Hospital Management Information System would allow the Home to have "state-of-the-art" technology allowing Home management to make more timely and appropriate management decisions, to more effectively monitor the quality of care rendered, and to maximize the collection of all potential reimbursable charges.

As you may know, it was noted in the Bureau of State Audit Report of 1994 that the Home was not collecting all potential reimbursements. Estimates of uncollected reimbursements were based on studies done in the late 1980's. As a consequence of the findings in that report, the Home made significant strides in improving its reimbursements. In the last two years alone, reimbursements have increased from $25.1 million (1994-95) to a projected $ 27.9 million in 1996-97; an increase of $2.8 million. Notwithstanding that the Veterans Home is partially supported from the State's General Fund, it has taken the initiative to maximize reimbursements with the limited resources available. However, a state-of-the-art healthcare, hospital information system would allow for even greater success than has already been achieved.

We are also pleased that the audit staff review of the Home's Laundry Services and Dietary and Food Services suggest that it would be more cost beneficial to contract for these

services with the private sector. A recent study funded by the Legislature on the Home's laundry facilities and capabilities confirms the current Audit Report findings. The authorization and final approval of the State Legislature would allow us to contract with qualified vendors to provide these important services to our veterans.

The Home's specific responses to the findings and recommendations of the report are as follows:

SUMMARY

Quality of Care Issues:

In a number of sections within the audit report, the audit staff has raised issues relative to the operations of the Veterans Home and "quality of care". We believe that the Veterans Home provides the highest quality of care to our aged and fragile veterans and, in most instances, the quality of care exceeds industry standards. When a veteran requires healthcare services or support beyond the Veterans Home's resources, other arrangements are promptly made to refer veterans to the appropriate health care facility which can best meet their needs. We have the capability to transfer acutely ill patients needing tertiary care to a local community hospital such as the Queen of the Valley Hospital or St. Helena Hospital, or to the Veterans Administration Medical Center at Fort Miley which is affiliated with the University of California, San Francisco Medical Center.

Reimbursements and Costs:

The Audit Report states that "because Yountville has not been held accountable to financial performance measures other than the annual budget, there is a lack of incentive and initiative to maximize reimbursement and reduce costs."

We do not fully agree with this perception. An audit conducted by the Bureau of State Audits in 1994 found that, without a Management Information System, the Veterans Home was not maximizing its reimbursements. As a result of that report, the Veterans Home undertook a number of measures to increase reimbursements. As noted above, reimbursements have increased almost $3 million over the last two years even though we are on a manual and labor intensive system. Further, many new programs, previously not billed to Medicare, have been implemented to improve the amount of reimbursement received at the Veterans Home. We are billing new Medicare programs, including the Part B component for rehabilitation services, pharmacy services, and optical services. In addition, we have begun working with the Alcohol and Drug Treatment Program, which includes a Social Rehabilitation program, to identify billable services and maximize billing of all their services. We have also implemented procedures for billing third party payers such as HMOs and other insurance companies, when applicable. Our very aggressive actions to increase Aid and Attendance reimbursements have also resulted in an overall increase of some $500,000 over previous 1994-95 Aid and Attendance collections.

With respect to costs, we are continually pursuing more cost-effective and cost-beneficial means of providing the highest quality services required by our aged and frail veterans.

Collection of Member Fees:

The audit finding states, "It is not clear whether the low average collections are due to low monthly income by the veterans or Yountville not fully collecting members fees."

Member fees and charges were codified in AB 3635 (Knight) which sets monthly fees at 55% up to a maximum of $1,200 in Residential Care, 65% up to $2,300 in Intermediate Care, and 70% up to $2,500 in Skilled Nursing Care. Given that the current average income of veterans residing at the Veterans Home is $1,094, the low collections are due to low average income. In addition, the Veterans Home's current bad debt percentage on member fees is approximately 1% of the total fees collected.

CHAPTER 1: THE VETERANS HOME AT YOUNTVILLE COULD IMPROVE ITS DELIVERY OF MEDICAL CARE

Yountville Could Realize An Improved Quality of Care, Increased Reimbursements, and Decreased Costs By Developing a Home Health Agency.

The Veterans Home's Home Health Care service was licensed briefly from June 1989 until June 1990. However, we concur with the audit recommendation that the Veterans Home should re-explore establishing a licensed Home Health Care agency.

Since July 1990, we have been providing healthcare assistance to veterans in residential areas by support staff operating under the direction of the primary care physicians. This support consists of Residential Care Team conferences on patient care management, visits to the residential areas by a Registered Nurse and a part-time Certified Nursing Assistant, the provision of prosthetic assistive devices, and Meals on Wheels. Our goal is to maintain and improve functionality so that residents can "age in place" in their residential home. Only when resources are exhausted and Medi-Cal criteria are met, will a veteran be transferred to a higher level of care. Our first examination of the impact a home health service will have on the availability of ICF and SNF beds indicates that it is unlikely that a significant number of intermediate and skilled nursing beds will be opened. But, we do agree that it creates potential Medicare reimbursements that could be collected to cover the cost of the services.

We believe a Home Health Care Service is consistent with our on-going policy to maintain the health of our veterans at the lowest level of care possible and to safely maintain their sense of independence, self-worth and well being. It is the Veterans Home's intent to re-explore the requirements for licensure and we will request the required staffing through the normal budget process.

The Cost-Effectiveness and Benefits of Operating a Hospital at Yountville Are Questionable.

The licensure and operation of 26 beds as an acute care hospital have been an important part of the history and success of the Veterans Home of California. Nationally, acute care hospitals are presently going through dramatic restructuring and re-engineering to become more efficient and cost effective. It is only reasonable that modification and adjustment be made regarding acute care services for the veterans who are residents of the Home. Therefore, the department concurs with the audit findings that a comprehensive study be done to determine the feasibility of the elimination of acute care services on site or whether a modification and/or restructuring of the existing on-site service would be more appropriate. The Veterans Home has already initiated discussions with the University of California at Davis Medical Center regarding the feasibility and practicality of contracting for telemedicine service for radiology and electrocardiographic interpretations and psychiatric consultations. Discussion has also been initiated between the Veterans Home and the federal Veterans Integrated System Network 21 to determine the feasibility of providing urgent care and triage services, utilizing existing services at the Home, for qualified veterans living in the immediate area in addition to the Home members. These and other options should be explored thoroughly before dismantling the acute care component of the Veterans Home's comprehensive health care program. Further, a thorough review of the current acute care costs and resulting revenues is imperative to any decision to discontinue these services. Hospital based skilled nursing facilities are reimbursed at higher rates than free-standing SNFs.

CHAPTER 2: THE VETERANS HOME AT YOUNTVILLE CAN REDUCE THE COSTS OF ITS MEDICAL STAFF

Physician Staffing Ratios within the Nursing Home Are Inconsistent With Statewide Benchmarks.

The Employment Arrangements of Physicians At Yountville Are Costly.

While it is technically correct that the Veterans Home of California, Yountville has twenty-four (24) medical staff employees (See Attachment I), only ten (10) physicians are full-time primary care physicians. The other medical staff employees are for specialty or ancillary medical services, including four (4) medical staff employees who are permanent/intermittent classifications, working no more than 200 hours per calendar year.

Also employed by the Veterans Home are two (2) full-time dentists, one (1) full-time psychologist, one (1) full-time podiatrist, one (1) full-time radiologist, one (1) full-time pathologist and one (1) half-time psychiatrist. It should be noted that the medical staff is under the direction of the Chief Medical Officer, Chief of Medicine and the Chief, Ambulatory Care. The Chief Medical Officer supervises all medical staff and eleven medical service areas. The Chief of Medicine and the Chief, Ambulatory Care Service spend from fifty percent (50%) to sixty percent (60%) of their time per week providing primary care physician duties while the rest of their time is utilized performing Administrative duties. In addition, four (4) permanent

intermittent physicians are used to fulfill licensing and patient care requirements in the areas of surgery, radiology, oral surgery and infectious disease.

In response to the statement "Because of either excess physicians on staff, low productivity among the physicians, or inadequate billing for physicians visits, the Veterans Home incurs more that $1.8 million in unreimbursed physicians costs annually" (Ch5-2, Physician Resources, Paragraph 1) we provide the following comments:

1) Generally speaking, physicians practicing independently in the community generate a gross income which is twice their salaries because the standard overhead for physicians varies between 40% and 60%. In an institutional setting, if there is no duplication of services, the overhead should be close to 40%. Because the Veterans Home does not have a Management Information System, it is difficult to determine the actual income generated by physicians. Until the Veterans Home has an MIS, however, we will work toward improvement of our manual procedures and will educate our physicians on proper documentation of services and charges in order to capture as much physician reimbursement as possible. (1)*

2) There are no private industry standards which can be exactly compared to a Veterans population other than similar veterans retirement and healthcare facilities or general hospitals located in retirement communities, i.e., Sun City, Arizona. Unfortunately, it is also difficult to compare the Veterans Home of California, Yountville with the Federal Veterans Administration system. All studies done on Veterans have shown that they utilize more medical care and healthcare resources for a variety of reasons, i.e. prior history of no preventive health care, poor health maintenance habits, abuse of tobacco, alcohol and other drugs, and fewer financial and psychosocial resources.

3) Productivity standards and performance measures for all staff physicians are key to establishing current workloads and staffing levels. We agree we need to further develop our productivity standards and performance measures for all Medical staff. We have been limited in assessing productivity of our physicians due to the lack of an adequate Management Information System (MIS). However, we have taken recent measures to more accurately assess the productivity and performance of our medical staff. As a result of these measures, we have recently had a physician with low productivity retire and anticipate another retirement in the near future.

4) We concur that reorganization of our present medical staff will enable us to omit two Physician/Surgeon positions. We have already taken steps in this direction, albeit slowly, so we do not compromise patient care. The elimination of a third Physician and Surgeon position can only be justified if further reorganization takes place, we provide for the hiring of Physician extenders, i.e., Geriatric Nurse Practitioners (GNP) and Physician Assistants (PA), and we allow for natural attrition of Medical staff who are less productive.

5) We do not dispute the fact that our current billing and reimbursement system is

* Our comments on the response from the Department of Veterans Affairs begin on page 61.

inadequate. We have been unable to adequately track Medical staff billing accuracy with maximal reimbursement due to lack of a MIS. This system would greatly improve our efforts in the above concern and will insure that all physician visits are billed accurately with increased reimbursement. With respect to physician billings, the Veterans Home has undertaken new procedures and processes to ensure physician education and manual tracking of all physician services billable to Medicare or Medi-Cal. With the implementation of a new Management Information System, this tracking system will be even more successful.

6) We recognize the necessity of exploring the feasibility of outsourcing our Pathology and Radiology Physician and Surgeon positions.

Nursing Staffing Ratios Are Inconsistent with Statewide Benchmarks.

We concur with the recommendation that the Veterans Home can adjust some of its nursing staffing mix between Registered Nurses and Licensed Vocational Nurses. However, we believe that the adjustment has less of an impact than recommended by the audit staff. We also do not concur with the recommendation of replacing licensed staff with Certified Nurse Assistants.

1) Prior to the Master Plan renovation, commencing in 1985, the antiquated patient care areas at the Veterans Home consisted of dormitory style, open-bay wards ranging in capacity from 34 to 66 beds per ward.

2) With the Federal and State regulations emphasizing a patient's right to privacy and dignity and the current building codes, a dormitory style of ward was no longer acceptable. Because all of the buildings were part of the Historical Registry, remodeling had to be consistent with existing external walls and configuration. It was determined that remodeling the existing buildings was more cost effective than new construction. The lack of flexibility for architectural design resulted in an inefficient patient care configuration. As a consequence, dormitory ward size was reduced from 34 to 66 beds to semi-private room ward size of 20 to 37 beds.

3) With this reduction the Veterans Home has lost its staffing economy of scale. Of the 18 long term care wards currently open, 13 have a ward capacity of 20 to 25 beds, which is not economically efficient for a SNF or ICF facility, and definitely not the community standard to which the Veterans Home is being compared.

4) In the auditors recommendations the average size SNF or ICF was not stated, but the average staffing ratio is given as 10% Registered Nurses, 18% Licensed Vocational Nurses and 72% Certified Nurse Assistants. As none of our wards are what we would consider average size, we must utilize the average staffing

ratio as a reference point, but then must take the characteristics of the Veterans Home, Yountville into account when determining the appropriate staffing ratios.

5) The requirement which requires a facility to consider its unique characteristics in its staffing plan is addressed in Title 22 regulations, §73319 (see attached). These inefficient characteristics, includes the small size of our wards, the configuration of our wards, and the fact that 10 of our wards are located outside of the main building.

6) When the audit findings realigned the staff they recommended that approximately 38 FTEs, currently classified as licensed, be reclassified as Certified Nurse Assistants. Certified Nurse Assistants cannot perform the duties of a licensed staff person, such as passing medications, performing treatments, monitoring intravenous fluids (IVs), or developing patient care plans. There is no other classification, within the State of California, other than Registered Nurse and Licensed Vocational Nurse, that is licensed to pass medications. Therefore, Certified Nurse Assistants cannot replace licensed personnel. (2)

7) Currently 13 of the 18 long term care wards only require one licensed staff per shift. We cannot reduce the number of licensed staff below this level, as we currently have only the minimum number of licensed staff assigned to perform the licensed duties and to meet the health and safety needs of our members.

In keeping with trying to shift the ratio of Registered Nurses to Licensed Vocational Nurses, we have reviewed our utilization of licensed staff and feel that if we concentrate the Registered Nurses on the day shift and realign the licensed workload so that those tasks that are exclusive to the Registered Nurse classification are performed on the day shift, we could reallocate positions within the licensed staff category. In keeping with this, Yountville is currently developing a policy and an education program for Licensed Vocational Nurses to be allowed to administer IVs. This is the only duty within the Licensed Vocational Nurses scope of licensure that Veterans Home policy does not currently permit LVNs to perform. (3)

Table 1 shows Yountville's current staff mix ratio, our proposed staff mix ratio and the amount of anticipated annual savings of $277,370 per year.

TABLE 1

	CURRENT	PROPOSED	NEW RATIO	SAVINGS
RN	64.5	46.5	16.5%	769,720
LVN	42.6	60.6	21.6%	(492,350)
CNA	173.4	173.4	61.9%	0
TOTAL	280.5	280.5	100%	277,370

Nursing Salaries at Yountville Are Inconsistent With State Benchmarks.

While we concur with the findings of the Audit Report, nursing salaries for Registered Nurses, Licensed Vocational Nurses and Certified Nursing Assistants are negotiated through the collective bargaining process. The Veterans Home does not have direct control over the establishment of salaries for its nursing staff. As noted above, the Veterans Home intends to re-evaluate its staffing mix between RNs and LVNs to establish a staffing mix more comparable to industry standards. This staffing mix will also take into consideration the size and configuration of the various wards in licensed areas.

CHAPTER 3: THE VETERANS HOME AT YOUNTVILLE DOES NOT MAXIMIZE ITS MEDICARE AND MEDI-CAL REIMBURSEMENTS

Yountville Is Not Maximizing Its Medicare Reimbursements for Skilled Nursing.

The audit report recommends that the Veterans Home develop a Certified Distinct Part (CDP) to properly isolate and report all of the costs associated with providing skilled nursing care to Medicare-eligible patients. The Veterans Home is currently reviewing the feasibility of developing a Certified Distinct Part within the ward layout of the Veterans Home. However, we would note the following concern with this proposal:

- The veteran would no longer receive Medicare covered SNF services on his or her home ward. Veterans eligible for Medicare would be transferred to one area designated a Medicare Certified Distinct Part for billing purposes. When the veteran no longer qualifies for Medicare payment, the veteran would have to be transferred. Upon discharge from the CDP, the veteran most likely would not be able to return to his or her home ward. The veteran would be transferred between the CDP and a non-CDP each time his or her Medicare status changes. This is contrary to the Veterans Home's objective of remaining in a "home" unit where the staff is aware of medical problems and needs. (4)

- With respect to training, the Veterans Home will be developing a training program to ensure that the appropriate staff are well trained in Medicare and Medi-Cal regulations and industry standards.

Yountville's Use of Skilled Nursing Beds is Inconsistent With Industry Practice.

As was indicated to the audit staff, the Veterans Home uses the Medi-Cal criteria contained in the Department of Health Services rules and regulations for level of care determinations. Adherence to the Medi-Cal guidelines preclude the Veterans Home from incorrectly placing ICF residents into SNF levels of care. We question the necessity of a clinical acuity study. While we would not be averse to such a study, the usefulness and cost justification warrants further explanation. Since skilled nursing patients are reviewed using skilled criteria as defined by Medi-Cal, regardless of payment source, Medi-Cal review of skilled patients serves as a random sampling of appropriate skilled nursing placement. During the 1995-96 fiscal year, 101 cases were reviewed by Medi-Cal Field Services, Department of Health Services, with only one case denied. Utilization review identified the patient as an (5)

inappropriate placement and denied the case prior to the Medi-Cal denial. Since Department of Health Services, Medi-Cal Field Services is continually reviewing the Veterans Home placement determinations, the need for the study could be averted.

In regard to Medicare reimbursed skilled patient days, hospital discharges do not necessarily result in Medicare reimbursed skilled patient days if any of the following apply:

1. The hospital stay was non-qualifying.
2. The patient was discharged to a lower level of care (ICF or residential).
3. The veteran's Medicare benefits are exhausted.
4. The Medicare skilled nursing facility criteria are not met.

In addition, a comparison of the Veterans Home to private sector nursing homes cannot be easily done since, unlike private or for-profit nursing homes, the Veterans Home cannot screen new veterans for the ability to pay. If a veteran no longer qualifies for Medicare reimbursement and does not meet the financial needs eligibility requirements for Medi-Cal, the veteran's family is not sent a denial of payment letter and requested to provide some third party payment.

With respect to locating all skilled nursing veterans in a common area, we believe that with the current renovation and ward configuration of previously renovated facilities, this recommendation is not feasible due to the configuration of our facility. Since 1985, we have been in the process of renovating the facility to meet current State, Federal and VA Health, Safety and Building codes. Wards have been constantly emptied and filled to allow the facilities to undergo the remodeling process. Providing all skilled nursing in one common area cannot be considered. Further, it is not the Veterans Home policy to house SNF and ICF patients in the same building now and in the future. (6) (7)

CHAPTER 4: THE VETERANS HOME AT YOUNTVILLE NEEDS TO IMPROVE ITS MANAGEMENT INFORMATION SYSTEM AND COULD REDUCE SOME COSTS THROUGH OUTSOURCING

Yountville's Management Information Systems Are Inadequate.

We concur that the Veterans Home needs a more comprehensive Management Information System (MIS). The California Department of Veterans Affairs (CDVA) is implementing the Veterans Home Information System (VHIS) at the Barstow Veterans Home. This is an "off-the-shelf" software product that will require only minimal modifications to conform to the needs of the CDVA (interface to CALSTARS; reports to OSHPD). The software and hardware vendors have a long-term working relationship and have implemented this software in hundreds of hospitals and care facilities nationwide.

Successful implementation of the VHIS is a top CDVA priority. To ensure that the VHIS will be a comprehensive system for the Veterans Homes in California, staff from both

Homes (Yountville and Barstow) are actively involved in all aspects of VHIS implementation at Barstow, and will also be involved in the planning and implementation at Yountville.

Additionally, the CDVA will develop a plan for alternative interim PC-based solutions, identifying costs for the software and equipment. As noted, a separate request has been submitted for the necessary wiring for Yountville. The plan will be submitted to the appropriate control agencies for review and approval.

The Veterans Home Could Realize Significant Cost Reductions Through Outsourcing of Laundry and Dietary Services.

Dietary and Food Services:

The department would not be opposed to Legislative support to outsourcing its dietary and food services. We would note that the Legislature has appropriated a $9,951,000 ($3,311,000 General Fund) capital outlay project to renovate the Veterans Home's main kitchen, dining room and hospital kitchen.

Laundry Services:

We concur with this recommendation. The 1995-96 Budget contained $15,000 to conduct a study of the Veterans Home's laundry facilities. The Veterans Home contracted with Western State Design to review the Veterans Home's current laundry facilities and to make recommendations as to the most cost-effective means of providing laundry services. The study concluded that:

- Operating an on-premise laundry under existing conditions or with a new state-of-the-art system cannot be provided on a cost effective basis, due to high operating costs and substantial renovation costs.

- Annual operating costs for contracting with Prison Industry Authority (PIA) and with commercial enterprises are similar. However, under PIA, an initial investment in linen of $500,000 would be required to maintain Title 22 linen inventory levels in the event of a prison "lock-down".

Based on these findings, Western State Design recommended that the Veterans Home should contract with a commercial laundry service for all linen requirements and reduce operating staff accordingly. The Veterans Home has begun negotiations on the labor issues which would allow the Veterans Home to contract with a private sector laundry provider specializing in healthcare, however, it is our understanding that legislation would also be required to exempt the Veterans Home from PIA laundry services.

The audit report is received as welcomed support for our on-going efforts to improve medical operations and increased reimbursement levels at the Veterans Home of California. The report offers constructive recommendations on how the Home can increase reimbursements and be more efficiently managed. In addition, the report helped us identify

and correct those areas which are not consistent with healthcare industry standards. We would like to commend the staff of Ernst and Young LLP and the Bureau of State Audits as each conducted its tasks professionally and courteously at all times and worked closely with the department in understanding the operations of the Home.

We are also confident that you will give careful consideration to our responses to the audit report. If there are any questions, please do not hesitate to contact me at (916) 653-2158 or James D. Helzer, Administrator, Veterans Home of California at (707) 944-4500.

Sincerely,

JAY R. VARGAS
Secretary

Attachments

cc: Lee Bennett, Undersecretary
Loren Suter, Deputy Secretary, Administration
Sheryl Schmidt, Deputy Secretary, Women Veterans Affairs
Dennis Hutcheson, Assistant Administrator
Dianne M. Winne, MD, VHC-Yountville
Kathryn M. Razi, RN, VHC-Yountville
R. Bruce Phillips, VHC-Yountville

ATTACHMENT 1

CLARIFICATION OF THE AUDIT FACTS REGARDING MEDICAL STAFF

The exact makeup of Medical staff personnel at the Veterans Home of California, Yountville as of January 21, 1997 is as follows:

CLASSIFICATION	NUMBER FTE's
Chief Medical Officer	1
Chief, Physician and Surgeon (Chief of Medicine & Chief Ambulatory Care)	2
Physician and Surgeon - Intermediate Care	2
Physician and Surgeon - Skilled Nursing Care	3
Physician and Surgeon - Skilled Nursing Care/Dementia	1
Physician and Surgeon - Ambulatory Care	4
Physician and Surgeon - Radiologist	1
Physician and Surgeon - Pathologist	1
Chief, Dentist	1
Dentist	1
Podiatrist	1
Staff Psychologist	1
Staff Psychiatrist	5
Total FTE's	**19.5**

In addition four (4) permanent intermittent physicians are used to fulfill licensing and patient care requirement in the areas of Surgery, Radiology, Oral Surgery and Infectious disease. These physicians provide services approximately one hundred (100) to two hundred (200) hours per calendar year.

(i) Medications brought by or with the patient to the facility shall not be used unless all of the conditions specified in Section 73363 are met.

(j) A registered nurse or a pharmacist shall review each patient's medications monthly and if appropriate, request a review from the patient's attending physician.

§ 73315. Nursing Service—Patient Care.

(a) No patient shall be admitted or accepted for care by an intermediate care facility except upon the order of a physician.

(b) Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

(c) Each patient, upon admission, shall be given proper orientation to the intermediate care facility and the facility's services and staff.

(d) Each patient shall show evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails and shall be free of offensive odors.

(e) Each patient shall be encouraged and/or assisted to achieve and maintain his highest level of self–care and independence. Every effort shall be made to keep patients active except when contraindicated by physician's orders.

(f) Such supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided.

(g) Treatment for minor illness or routine treatments for minor disorders when ordered by the physician shall be administered by nursing personnel.

(h) Bedside nursing care may be provided on a temporary basis when the attending physician determines the illness to be temporary and minor.

(i) When a patient requires services which are not considered to be intermediate care services, the physician shall be notified and arrangements made to transfer the patient from the intermediate care facility.

§ 73317. Nursing Service—Policies and Procedures.

(a) Written policies and procedures developed by the supervisor of health services and approved by the Patient Care Policy Committee shall be available to all nursing personnel. Such policies and procedures shall include:

(1) An organization chart of the nursing service showing staff positions, lines of authority and communication.

(2) Specific instruction on the preparation, review and updating of individual patient care plans.

(3) Orientation procedures and programs for new employees.

(4) An ongoing education program planned and conducted for the development and improvement of skills of all facility's personnel including training related to problems and needs of the aged, ill and disabled.

(5) A current nursing procedure manual.

§ 73318. Nursing Service—Nurse Assistant Training and Certification.

NOTE: Authority cited: Section 1137.7, Health and Safety Code. Reference: Chapter 351/1978 (AB 2567).

HISTORY

1. Repealer and new section filed 1–12–79 as an emergency; effective upon filing (Register 79, No. 2). For prior history, see Register 77, No. 52.
2. Certificate of Compliance filed 4–16–79 (Register 79, No. 15).
3. Repealer filed 7–16–91 as an emergency; operative 7–16–91 (Register 91, No. 46). A Certificate of Compliance must be transmitted to OAL by 11–13–91 or emergency repeal will be reinstated by operation of law on the following day.
4. Repealer refiled 11–14–91 as an emergency; operative 11–14–91 (Register 92, No. 8). A Certificate of Compliance must be transmitted to OAL 3–13–92 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4. and repealer refiled 5–6–92 as an emergency; operative 5–6–92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 9–3–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–6–92 order transmitted to OAL 8–27–92 and filed 10–9–92 (Register 92, No. 41).

§ 73319. Nursing Service—Staff.

(a) Nursing service personnel shall be employed in the number and with the qualifications determined by the Department to provide the necessary services for those patients admitted for care. The Department may require a facility to provide additional staff whenever the Department determines through a written evaluation of patients and patient care in the facility that such additional staff are needed to provide adequate nursing care and treatment or to provide for the safety of the patients.

(b) Facilities shall employ a registered nurse or licensed vocational nurse eight hours per day on the day shift, seven days per week. In case of facilities where a licensed vocational nurse serves as supervisor of health services, consultation shall be provided by a registered nurse, through formal contract, at regular intervals, but not less than four hours weekly.

(c) Facilities with 100 or more beds shall employ a registered nurse eight hours per day, on the day shift, seven days per week. In addition, a registered nurse or licensed vocational nurse employed four hours per day, seven days per week, during the day for each 50 beds or portion thereof in excess of 100.

(d) Nursing stations shall be staffed by nursing personnel day and night when patients are housed in the nursing unit.

(e) Each facility shall employ sufficient staff to provide a minimum average of 1.1 nursing hour per patient day.

(1) Facilities which provide care for mentally disordered or developmentally disabled patients and in which licensed psychiatric technicians provide patient care shall meet the following standards:

(A) If patients are not certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum average of 1.1 nursing hour per patient day.

(B) For patients certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum average of 0.7 nursing hour per patient day for each patient certified to the special treatment program, exclusive of additional staff required to meet the staffing standards of the special treatment program.

NOTE: Authority cited: Sections 208(a), 1275 and 1276.5, Health and Safety Code. Reference: Sections 1276 and 1276.5, Health and Safety Code; and Section 14110.7(c), Welfare and Institutions Code.

HISTORY

1. New subsection (e) filed 7–1–77 as an emergency; effective upon filing (Register 77, No. 27).
2. Certificate of Compliance filed 10–27–77 (Register 77, No. 44).
3. Amendment of subsection (e) filed 9–23–85 as an emergency; effective upon filing (Register 85, No. 39). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–21–86.
4. Certificate of Compliance transmitted to OAL 1–17–86 and filed 2–10–86 (Register 86, No. 7).

§ 73321. Nursing Service—Equipment and Supplies.

(a) Equipment and supplies of the quality and in the quantity necessary for care to patients, as ordered or indicated, shall be provided and shall include but not be limited to:

(1) Water pitchers, emesis basins, denture cups, ice caps, urinals, bedpans, thermometers, stethoscope, sphygmomanometer, ear syringe, hypodermic syringes and needles and scales for weighing patients.

(2) A sufficient supply of wheelchairs and walkers to meet the intermittent needs of patients and maintained in clean and operable condition.

(3) Supplies necessary to perform urine sugar and acetone testing.

(4) Current and authoritative nursing reference material.

(5) First aid equipment and supplies, as determined by the patient care policy committee, readily available at all times.

§ 73323. Dietetic Service—Defined.

"Dietetic service" means a service organized, staffed and equipped to assure that food served to patients is safe, appetizing and provides for their nutritional needs.

§ 73325. Dietetic Service—Food Service.

(a) The dietetic service shall provide food of the quality and quantity to meet the patient's needs in accordance with physicians' orders and, to the extent medically possible, to meet "the Recommended Daily Dietary

Comments

Comments on the Response from the Department of Veterans Affairs

To provide clarity and perspective, we are commenting on the Department of Veterans Affairs' response to our audit report. The numbers correspond to the numbers we have placed in the response.

(1) The management of the Veterans Home at Yountville (Yountville) asserts that there is no comparable provider or industry segment that can be used to benchmark the performance of the facility. While Yountville is unique in some ways, the facility is not, and should not be, beyond comparison to norms in the health care industry. We do not feel that the health care needs of the patients at Yountville are significantly different from many types of facilities and patient populations that are part of the State's Office of Statewide Health Planning and Development data bases or other facilities throughout the United States. In order for private providers to remain financially viable, they have had to compare their facility's performance to benchmarks and make adjustments as the industry changed. Yountville has not historically monitored typical industry standards nor used standards to measure their operations and therefore has not changed with the industry. As long as Yountville chooses to ignore industry benchmark comparisons, it will continue to significantly deviate from industry norms as the industry evolves.

(2) At no point in the report did we state or insinuate that Certified Nurse Assistants could or should perform the duties and responsibilities that can only be performed by licensed nursing personnel. Based upon our comparison of Yountville to other facilities, it appears that registered nurses (RNs) at Yountville perform some of the duties that could be more cost-effectively performed by either licensed vocational nurses (LVNs) or nurses' aides (aides).

(3) While we are pleased that Yountville is taking the opportunity to realign its nursing staff and achieve some rather significant savings, Yountville does not address the appropriateness of the duties assigned to RNs and LVNs compared to the duties

assigned to aides. We believe that further savings are attainable if duties that do not require a license are performed by aides rather than RNs and/or LVNs. We believe that Yountville needs to take their analysis further to maximize the use of all nursing staff and to ensure they are performing the duties that are appropriate for their classification.

(4) The use of a Medicare "certified distinct part" (CDP) is not solely for those veterans eligible for Medicare skilled reimbursement. A Medicare CDP should be used for the care of all veterans who require rehabilitative, high-skilled care services. The CDP should be used as the "intensive care unit" of a long-term care facility. If a veteran requires rehabilitative and high-skilled care, he or she should be placed in the Medicare CDP. Once this level of care is no longer required, the veteran should be returned to the next lower level of care that can safely meet their needs. It is inefficient to provide health care personnel and services at an "intensive" level that is significantly greater than the need. Also, mixing patients with high-skilled needs among those with lower-level needs can adversely affect the quality of life and care for both groups. Finally, Yountville's current approach of certifying the entire skilled area for participation in Medicare negatively affects its ability to track and be reimbursed for its true costs associated with higher care need veterans.

(5) Only 11 percent of the veterans in the skilled-care area of Yountville are Medi-Cal eligible and subject to an eligibility file review by the Department of Health Services (DHS). Our concern is with the proper classification of the other 89 percent of the population that are not reviewed by the DHS. We continue to believe that a study of the appropriateness of the level of nursing care assigned to that portion of the population not covered by Medi-Cal is warranted.

(6) While we recognize some of the difficulties with the physical configuration of the facilities at Yountville, we are not aware of any formal study or analysis that supports their claim that they cannot provide all skilled nursing in one common area. We are disappointed that Yountville dismisses a rather simple and logical recommendation to consolidate its skilled nursing care without thoroughly assessing the possibilities.

(7) We do not advocate housing SNF and ICF patients in the same setting. To the contrary, we recommend that these populations be properly classified according to their care needs and that such care should be provided in separate and distinct areas.

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps